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:	Hall Lodge
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Unannounced
Date of inspection:	11 July 2024
Centre ID:	OSV-0001709
Fieldwork ID:	MON-0042967

About the designated centre

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

Hall Lodge is a designated centre operated by Sunbeam House Services CLG. The centre is located on a campus based setting near a large town in county Wicklow. Hall Lodge provides residential care and respite for up to four adults with intellectual disabilities with associated medical and physical support needs. The centre comprises one large property which provides residents with single occupancy bedrooms, a kitchen, communal living room areas, staff offices, a staff sleep over room, bathroom and toilet facilities; and a self-contained apartment attached to the property. The centre is managed by a person in charge who reports to a senior services manager, and is staffed by social care workers, nurses, and care assistants. Residents also have access to the provider's multidisciplinary team services.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 11 July 2024	10:30hrs to 19:00hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out as part of the ongoing regulatory monitoring of the centre, which had a poor history of compliance with the regulations, and to inform a decision on the provider's application to renew the registration of the centre. The inspector used observations, conversations with staff and the management team, engagement with a resident, and a review of documentation to make judgements on compliance with the regulations inspected.

While compliance was found under some regulations, overall the inspector found that the arrangements to assess and provide for residents' needs were not adequate, which impacted on the overall quality and safety of the service provided to them in the centre.

At the time of the inspection, the centre was registered to accommodate a maximum of four residents. There were two full-time residents living in the centre; the centre could also provide respite services for another two residents. However, respite services had been suspended since the beginning of the COVID-19 pandemic. The provider did not planning on resuming respite services until they were assured that the current residents' assessed needs were met. The provider had determined that this would require one resident to be discharged to an alternative service provider, and for the other resident's living arrangements to change. There was no confirmed time frame for these actions to be achieved, and subsequent to the inspection, the provider updated their application to renew the registration of the centre to accommodate a maximum of two residents.

The premises was located on a small campus style environment on the outskirts of a large town. It comprised a large main building accommodating one resident and an adjoining self-contained apartment accommodating the other resident. The inspector carried out an observational walk-around of the centre with the deputy manager. The apartment comprised a kitchen and dining room, a sitting room, a staff office, and an bedroom with en-suite bathroom. The main building comprised a large open plan living space, a kitchen, two smaller lounge rooms, staff offices, a medication room, bathrooms, storage rooms, the resident's bedroom, and vacant bedrooms.

Since the previous inspection of the centre in February 2024, considerable interior and exterior renovation works had been carried out. The works were primarily in the main building, and included repainting of rooms, new flooring and furniture in the sitting room, and full refurbishment of the main bathrooms and kitchen. The refurbishment of the kitchen included a wider entrance door to make it more accessible, and a height adjustable counter top to enable wheelchair users to be more involved in food preparation. Within the apartment, damage to walls had been repaired, and the garden had been enhanced to provide more outdoor space for the resident to use.

The premises had also been nicely furnished and decorated to be more homely. For

example, the furniture was comfortable, and in the main building, the resident's family photos were on display. The inspector also observed information on safeguarding, advocacy services, complaints, and human rights on display. However, the overall the layout, design and size of the premises remained unsuitable for the residents living there.

The inspector also observed good fire safety precautions in the centre, such as fire detection and fighting equipment, and means of exit.

The inspector spent time speaking with the resident in the main building. They did not communicate their views on the service provided in the centre, but did engage with the inspector through gestures, eye contact, and some words. They briefly spoke about visiting their family and plans to celebrate their upcoming birthday. During the inspection, they went with staff to a seaside town for a walk and coffee out, and in the evening planned to visit amusements.

The resident had an individualised communication plan, and the inspector observed a communication board in the main living room with pictures of staff and different activities. The social care worker assigned to support the resident told the inspector that the resident was supported to plan their day by choosing from pictures of activities and putting the pictures on the board.

The social care worker had commenced working in the centre in early 2024. They told the inspector that residents were well cared for, and that the staff team endeavoured to meet their needs. They said that residents had choice in their lives, and spoke about the activities they enjoyed such as walking, shopping, gardening, attending sports club and eating out. The social care worker also spoke about plans for one resident to resume swimming and join the Special Olympics. They were aware of the fire evacuation procedures and the how to respond to and report any safeguarding incidents.

The inspector observed the social care worker engaging with the resident in a kind and respectful manner, and the resident appeared familiar and comfortable with them. They also attended to the resident's wishes. For example, they made the resident a cup of tea as requested.

The inspector did not have the opportunity to meet the resident living in the apartment as they were out with staff for the day, or any of the residents' representatives. However, the inspector read a recent survey from one resident's family. Their feedback noted that "staff do their best", and that the resident had more choice about their activities in recent times. However, they also expressed concerns regarding the availability of multidisciplinary services, and how complaints made by them had been resolved in the past.

The inspection was facilitated by the person in charge, deputy manager, and senior service manager. They told the inspector about some of the improvements in the centre since the previous inspection, such as enhanced positive behaviour supports, implementation of communication plans to support residents to better express their wishes, completion of assessments by multidisciplinary team services, stabilisation of

staffing levels, and a decrease in the severity of behavioural incidents.

They also said that residents' general wellbeing had improved and that they had been availing of more community activities. They told the inspector about the different activities residents enjoyed, such as walking, shopping, equine therapy, eating out, gardening, being involved in household chores, visiting family, team sports, and watching sports. Residents had also gone on day trips to wildlife park in county Cork, and used the train to visit Wexford. The resident in the apartment had also invited the resident in the main building into their home for the first time to have dinner, which they both enjoyed.

The senior service manager also told the inspector that the person in charge had good oversight of the service, had implemented good communication and management systems, and was promoting a more inclusive and open atmosphere with person-centred care and support for residents.

However, the management team remained concerned that the centre was not suitable to meet either residents' needs, but in particular one resident's. While the provider had made efforts to address these issues, they remained outstanding and are discussed further in the report.

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

Capacity and capability

This unannounced inspection was carried out to assess the provider's compliance with the regulations inspected and to review how this was impacting on the quality and safety of the service provided in the centre. The findings of the report were also used to help inform a decision on the provider's application to renew the registration of the centre.

Overall, while there were some positive findings, the provider's ability to ensure that the centre was suitable and appropriately resourced to meet residents' full needs was inadequate. The provider was inspected five times between 2022 and 2024 before this inspection, with significant non-compliance found under several regulations, and in particular regulation 5. The provider recognised that they could not meet the residents' full needs. They had arranged for one resident to be discharged to another service provider, however there was no time frame for their move. They were also exploring possibilities for the other resident including reconfiguring the current environment or the resident moving to another home. However, there was no confirmation or time frame for either option.

The local management team included the deputy manager, person in charge, and a senior service manager who reported to a Chief Executive Officer (CEO). There were

arrangements such as regular management meetings for the management team to discuss and escalate issues, and the measures required to drive improvements in the centre.

The provider and person in charge had systems to monitor the quality and safety of the care and support provided to residents such as regular audits by the local management team and the provider's quality team. However, the effectiveness of these systems required improvement, as the inspector identified issues during this inspection that the provider had not self-identified and mitigated.

The inspector also found that the notification of incidents and events, as described under regulation 31, to the Chief Inspector of Social Services required better oversight to ensure that the information submitted was fully accurate.

The staff skill-mix included social care workers, nurses, and healthcare assistants. The management team were satisfied with it, but planned to review it to ensure that it was appropriate to the residents' needs. The management team told the inspector that the staffing levels had stabilised and increased consistency was contributing to a reduction in residents' behaviours of concerns. However, there were vacancies accounting for approximately a quarter of the total complement. While the person in charge managed the vacancies as best they could to reduce the impact on residents, there remained a risk to their continuity of care and support.

Staff were required to complete a suite of training. The inspector reviewed the staff training log with the person in charge, and found that some staff had not completed all mandatory training or required refreshed training, which posed a risk to the quality and safety of the service provided to residents. The inspector also reviewed the Schedule 2 files in respect of three staff working in the centre, and found a discrepancy in one file which was rectified by the provider following the inspection.

There were good arrangements for the supervision and support of staff, including management presence in the centre, and formal supervision meetings. The person in charge promoted an open and supportive work environment. Staff spoken with told the inspector that they felt well-supported by the local management team. They had no concerns, but felt confident in raising any potential concerns.

Regulation 14: Persons in charge

The registered provider had appointed a full-time person in charge. The person in charge was suitably skilled and experienced for their role, and possessed relevant qualifications in social care and management.

They were based in the centre to support their oversight of the service provided to residents, and was promoting the delivery of person-centred care and support in the centre.

Judgment: Compliant

Regulation 15: Staffing

The staff skill-mix comprised the person in charge, a deputy manager, healthcare assistants, social care workers, and nurses. The skill-mix was appropriate at the time of the inspection. However, the person in charge and senior services manager told the inspector that they planned to review the skill-mix to ensure that it best met the residents' needs.

The management team told the inspector that new staff had been recruited since the previous inspection, and they were having a positive impact by providing more stability for residents. However, open vacancies in the complement accounted for approximately 27% of the direct care support staff (nurses, social care workers, and healthcare assistants). The vacancies were being well-managed by the person in charge to minimise any adverse impact on residents. For example, regular relief and agency staff who were familiar with the residents covered the vacancies and mostly worked at night. Permanent staff also worked additional hours. The person in charge also endeavoured to ensure that a permanent staff member was always on duty.

The inspector viewed the planned and actual staff rotas for May, June and July 2024. They showed the names of the staff and the hours they worked. The May rota showed that two agency staff and one relief staff worked approximately 25 shifts. The June rota showed that two agency staff worked approximately 19 shifts. The July rota showed that four agency staff were to work approximately 35 shifts. These staff had all previously worked in the centre. While the vacancies were well-managed, there remained a risk to the residents' continuity of care.

The inspector reviewed the Schedule 2 files for three staff working in the centre. The files included evidence of identity, copies of qualifications, written references, and vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012. The qualification for one healthcare assistant was not available on the day of the inspection, but subsequently submitted to the inspector.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were required to complete a suite of training as part of their ongoing professional development and to support their deliver of effective care and support. The inspector viewed the up-to-date training records and found that some staff, most of whom were recently employed in the centre, had not received mandatory or

refresher training, such as:

- five staff required training, including some refresher training, in supporting residents to manage challenging behaviour
- three staff required first aid training
- one staff required infection prevention and control training
- one staff required training in supporting residents with modified diets

Some of the above outstanding training had been scheduled by the person in charge.

In January 2024, the provider's speech and language therapy service had recommended that staff attend a communication workshop. The deputy manager told the inspector that they had contacted the provider's training service to arrange the workshop and was awaiting a date for an available workshop.
The deficits in the staff training requirements posed a risk to the quality and safety of the care and support provided to them in the centre.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider had effected a contract of insurance against injury to residents and other risks in the centre including property damage.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure comprising the deputy manager, person in charge, and senior services manager who reported to a Chief Executive Officer. The person in charge was based in the centre to enable their oversight of the quality and safety of the service.

The provider and person in charge had implemented systems to monitor and oversee the quality and safety of care and support provided to residents in the centre. Annual reviews and six-monthly reports were carried out, along with a suite of audits in the areas of health and safety, medication, residents' finances, and infection prevention and control. The audits identified actions for improvement where required, which were monitored by the management team to ensure progression. However, the deficits found in residents' assessments and care plans did not demonstrate that oversight systems were wholly effective.

The provider had determined, with input from external expert services, that they did

not have the means to meet one resident's full needs in the centre. The provider had also determined that the other resident's living environment was not fully suitable. They had formed a steering group comprising the person in charge, senior services manager, CEO, and other members such as the provider's facilities, quality, and human resources department, to oversee the progress of their plans to ensure that residents' needs were assessed and being met. However, the overall progress of the provider's plans was slow and there remained no confirmed time frame for these matters to be resolved. The slow progress was also delaying the centre from operating as it was intended to; to provide respite services.

There were arrangements for staff to raise concerns. Staff spoken with told the inspector that they could raise any concerns with the management team, including the on-call service during out of normal working hours.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge had ensured that incidents, as detailed under this regulation, which had occurred in the centre were notified to the Chief Inspector. For example,

The inspector reviewed the records of incidents and events (as defined under this regulation) that had occurred in the centre since the previous inspection in February 2024. The inspector found that incidents, such as minor injuries, a serious injury, use of restrictive procedures, and allegations of abuse, had been notified to the Chief Inspector. However, the notification regarding the use of chemical restraint in the second quarter of 2024 did not accurately state the number of occasions the restraint was used. For example, medication administration records showed that the medicine was administered more times than noted in the notification.

Judgment: Substantially compliant

Quality and safety

While the provider had made efforts to improve the quality and safety of the service provided to residents in the centre, there remained deficits in the assessments of their needs and the associated arrangements to be in place. These deficits were repeatedly found in previous inspections of the centre and remained unresolved.

The provider had determined that residents' needs were not been fully met in the centre. They had engaged with external services and their own internal multidisciplinary teams to assess residents' needs. Some of these efforts were having a positive impact. For example, the inspector was told that the external

positive behaviour support had contributed to a reduction in the severity of behavioural incidents. However, the inspector found discrepancies in the completion, maintenance, and content in some of the residents' assessments and written care plans. Therefore, it was not demonstrated that the provider had determined each resident's individual needs, and while they had plans to ensure that their needs were met, there was no time frame for the achievement of these plans.

The provider had implemented arrangements to safeguard residents from abuse, and the inspector found that previous safeguarding concerns had been appropriately reported and responded to. However, some of the arrangements required review. For example, one staff required safeguarding training, and an intimate care plan was overdue review.

The premises comprised a very large main building (with a primary purpose to provide respite services) with an adjoining self-contained apartment. The premises provided ample space for residents to receive visitors. The inspector also observed a minimal use of environmental restrictions, and there were arrangements for the management of their use. Since the previous inspection of the centre, considerable upkeep and maintenance had been carried out, particularly in the main building. The inspector observed that it was clean, brighter, homelier, comfortable, and there was a more relaxed atmosphere. However, some additional upkeep was required to the premises, and overall the premises remained unsuitable for the residents living there.

The inspector observed good fire safety precautions, such as fire detection and fighting equipment, emergency lights, and availability of individual fire evacuation plans.

The provider had prepared a written medication management policy. The inspector reviewed some of the medicine practices during the inspection, such as the practices for storing, administrating, and monitoring the use of medicines, and found that some improvements were required as discussed under regulation 29.

Regulation 10: Communication

The inspector found that residents were being assisted and supported to communicate in accordance with their individual needs and wishes. Both residents had complex communication needs and means, which had been assessed by the provider's speech and language therapy service. Corresponding care plans were up to date and available to guide staff practices. Staff spoken with told the inspector about one resident's communication plan, and how they were supported to exercise their wishes and preferences. For example, they used some words and visual aids such as pictures. The inspector also observed new notice boards in both the main building and the apartment had been installed to assist residents to plan their activities.

Residents had access to a range of media sources. There were televisions in the

main living areas, and some residents used smart tablets and phones for listening to music and keeping in contact with their families.

Judgment: Compliant

Regulation 11: Visits

Residents could freely receive visitors in the centre and in accordance with their wishes. The premises provided ample and suitable private space for residents to spend time with their visitors.

Judgment: Compliant

Regulation 17: Premises

Since the previous inspection of the centre in February 2024, considerable renovations and refurbishments of the premises had been carried out. Overall, the inspector observed that the premises was brighter, clean, tidy, comfortable, nicely furnished, and well-equipped. For example, mobility equipment such as walking aids and ceiling hoists were available to residents, and were found to be up to date with their servicing requirements. The exterior was well-maintained and decorated with bright flower pots and raised beds for residents to use.

The works in the main building included:

- Full renovation of the two main bathrooms, including new flooring, sanitary ware, radiators, wall panelling, and installation of a new height-adjustable sitting and reclining assisted bath. The door between the bathrooms had also been sealed to ensure residents' privacy while using the bathrooms. The bathrooms presented a more inviting space for residents to use.
- The small bathroom, not used by residents, had also been fully refurbished.
- There was new flooring and furniture such as sofas and a coffee table in the living room, and the area had been repainted.
- The kitchen had been fully refurbished with new flooring, wall tiles, presses, cooking facilities and appliances. There was also a new height-adjustable table and the door into the kitchen had been widened to better accommodate wheelchair users. The kitchen was clean, bright and presented a pleasant environment to prepare and cook food.
- The staff room and utility room had been repainted and fitted with new flooring and furniture.
- The storage room had been fitted with new shelving to make better use of the space.

- The exterior roof fascias and gutters were replaced.

The building was also decorated to make it more homely for the resident living there. For example, their framed family photos and a visual activity board were displayed in the main living area, and their bedroom contained personal possessions such as soft toys. The inspector also observed the resident utilising the newly improved communal spaces. For example, they had tea in the kitchen. However, the layout and size of the premises remained unsuitable for their residential needs and parts of it were not conducive to a home-like environment.

Within the apartment:

- A hole in the kitchen wall had been repaired, damaged furniture had been removed, and the curtains had been cleaned.
- There was new office furniture in the staff room.
- The garden had been enhanced to provide more secure space for the resident to use. There was also a raised planting bed for the resident to do their gardening.

Some additional works were required, such as renovation to the vacant bedrooms in the main building, and minor upkeep to the apartment. However, the inspector read that additional works would be carried out once one resident had been discharged and the living arrangements of the other resident were determined.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider had ensured that a residents' guide was available to residents in the centre. The inspector viewed the guide and found that it was written in an easy-to-read format using pictures. It contained information on the services and facilities provided in the centre, visiting arrangements, complaints, accessing inspection reports, and residents' involvement in the running of the centre.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had implemented effective fire safety precautions in the centre. Staff had completed fire safety training. There was fire detection and fighting equipment, and emergency lights, and it was regularly serviced to ensure it was maintained in good working order. The fire panel was located in the main hallway of the main building and was addressable. The inspector released a sample

of the fire doors, including the bedroom doors, and observed that they closed properly. Some fire doors had been replaced since the previous inspection.

There were good arrangements for reviewing fire precautions. Personal evacuation plans had been prepared which outlined the supports residents required to evacuate. The inspector found that the plans were up to date. Fire drills, including drills reflective of night-time scenarios, were carried out to test the effectiveness of the fire plans. The night-time drill was overdue but scheduled to take place by the end of the month. The inspector also observed that the exit doors had easy-to-open locks to aid prompt evacuation of the centre.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The inspector reviewed the medicine practices and arrangements in place for the two residents living in the centre, and found that improvements were required to ensure that the practices aligned with the provider's policy.

Residents' medicines were securely stored in locked cabinets. Both residents had 'medication prescription administration record' sheets that included information on their prescribed medicines, and personal information such as any known allergies. The inspector reviewed the administration records from July 2024, which showed that staff had recorded when residents received their medicines. The inspector also found that written protocols were in place for PRN medicines (medicines only taken as required), and that there was an adequate supply of each medicine.

The inspector also counted the number of five different PRN medicines with the deputy manager, and checked them against the stock take records completed by staff. The number of four of the five medicines was correct. However, the records indicated that there should have been 40 tablets of a particular psychotropic PRN, but the count by the inspector and deputy manager found only 39. The deputy manager told the inspector that the discrepancy would be treated as a medicine error incident and investigated accordingly.

The inspector also observed that two PRN medicines were not labelled as per the provider's policy. The policy also indicated that medicines should be audited weekly. However, the inspector found that three medicines had not been checked in over one week.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector found that the assessment of residents' needs required improvement and there were deficits in the development and maintenance of written care plans. Overall, it was found that suitable arrangements were not in place to meet the residents' full needs. These findings have been repeatedly found during inspections of the centre.

The provider, and external professionals, had determined that the resident's needs were not being met in the centre. For example, a recent report from an external service commissioned by the provider, noted that the environment and living conditions were not suitable and needed to be changed. The provider had engaged with an external provider that could meet the resident's needs. However, there was still no confirmed time frame for when the resident would be discharged to them.

In addition, the inspector found deficits in the residents' health and social care assessments, and personal plans. For example:

- The statement of purpose detailed an assessment tool to be used to support residents to plan personal goals. However, the assessment was last completed in June 2020.
- The support needs form assessment, dated February 2024, had discrepancies that required updating, and additional information was required where needs were identified.
- A personal goals document was not dated, but appeared to be well overdue review as it referred to a previous person in charge and was written in the early stages of the COVID-19 pandemic.
- A care plan on a specific behaviour of concern that presented an infection risk was last reviewed in February 2023.
- A plan in relation to use of mobility equipment was not signed or dated to indicate when it was last reviewed.
- The health development plan, dated March 2023, was overdue review, and the inspector found that information regarding interventions for the resident's oral health and weight was not accurate.

The management team told the inspector that the other resident's living arrangement was also unsuitable. The provider had considered other properties for them to move to, and also considered reconfiguring the current premises to better meet their needs. However, no decision had been made on their living arrangements, and their needs and wishes with regard to their ideal arrangements had not been documented. For example, the management team told the inspector that the resident would require a spacious environment located in a certain area, but this information was not documented.

The inspector also found deficits in the residents' health and social care assessments and personal plans. For example:

- The support needs form assessment required revision regarding the resident's staffing support arrangements, and referred to activities which the inspector was informed that the resident had not engaged in since 2023 if not earlier.
- Not all interventions outlined in care plans were being carried out. For

example, the weight management plan stated that the resident should be weighed monthly. However, the resident was being weighed every second month.
- The personal outcome plan, dated January 2023, was overdue review.

Judgment: Not compliant

Regulation 7: Positive behavioural support

There were good arrangements to support residents to manage their behaviours of concern and for the oversight and management of restrictive practices. Staff had completed training in managing challenging behaviour and in-house positive behaviour support training. Since the previous inspection, an external service had completed an assessment of the residents' behaviour support needs and developed corresponding written care plans to guide staff practice. The management team told the inspector that the plans were being implemented and were having a positive impact in reducing the severity of behavioural incidents. In addition to these supports, the provider's own positive behaviour support were available to provide ongoing support to the centre.

There was a small amount of environmental and chemical restraints. The inspector reviewed the arrangements for one environmental restriction: the use of a sensor mat beside one resident's bed. The resident had a high risk of falling, and the mat was used at night-time to alert staff if they got out of bed unaided. The restriction was deemed to be the least restrictive option, and it had been approved by the provider's human rights committee.

Judgment: Compliant

Regulation 8: Protection

The registered provider and person in charge had implemented systems to safeguard residents from abuse, which were underpinned by a newly revised written policy. Staff working in the centre were required to complete safeguarding training to support them in the prevention, detection, and response to safeguarding concerns, and there was guidance for them in the centre to easily refer to. However, the staff training log showed that one new staff member (who started working in the centre approximately two months ago) required training.

The inspector found that safeguarding incidents in the centre had been appropriately reported and managed. For example, they had been reported to the relevant parties, and safeguarding measures were put in place.

Intimate care plans had been prepared to support staff in delivering care to residents in a manner that respected their dignity and bodily integrity. However, one resident's care plan, dated February 2023, was overdue review to ensure that its content remained accurate.
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	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Hall Lodge OSV-0001709

Inspection ID: MON-0042967

Date of inspection: 12/07/2024

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The skill mix has been reviewed and roles have been identified that best meet the residents needs. The PIC will continue to manage the roster to minimize any adverse impact on residents. Recruitment is ongoing for the current open roles, interviews took place 30/07/2024 one role was successfully filled. A full audit of Schedule 2 files were completed by the HR department, there will be monthly Audits conducted of Schedule 2 documents going forward.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Five staff required training, including some refresher training, in supporting residents to manage challenging behavior, These staff are scheduled to attend positive behavior support training for 19/08/2024. The full staff team completed additional positive behavioral support training on HSE land. Three staff required first aid training. Staff are scheduled for first aid training on 10/12/24, 15/10/24, 13/08/24, staff requiring training will be rostered with staff who have up to date training. One staff required infection prevention and control training, this staff is scheduled for training on 15/09/2024 One staff required training in supporting residents with modified diets This staff is scheduled for training on 15/09/2024. All staff have completed compulsory communication training, there is a library of additional communication supports available for all staff on the providers database , There are non compulsory communication workshops available throughout the year also.	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A full audit was completed 01/08/2024 of residents assessments and care plans. A local audit system is in place going forward the PIC or Deputy Manager will audit residents care plans and assessments on quarterly basis or more often as required

The provider continues to liaise with the external service provider and the residents family, there is a further meeting date scheduled in August.

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PIC has identified the error in the number of chemical restraints notified and has discussed with staff in team meetings and via emails the importance of accurately recording use of chemical restraints which will allow PIC to ensure accurate report.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The provider continues to liaise with the external service provider and one residents family, there is a further meeting date scheduled in August.

The provider continues to review options for other alternative premises for one resident which will provide a more homely environment.

There is a planned schedule in place to complete outstanding works to be completed by 24/10/2024.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
A Drug error workflow was completed to reflect the missing one PRN tablet.

The expiry date was omitted from labels received from the pharmacy , the PIC has followed up with pharmacy and requested expiry dates on labels going forward.

The PIC arranged for a medication Audit on 30/09/24 , actions from this audit will be addressed.

The PIC will ensure medication Audits take place in line with Policy.

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:
A full audit of residents care plans was carried out 01/08/2024, actions from this will be

addressed by 31/08/2024 Residents personal goals have been reviewed and completed on 01/08/2024	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: One staff member requires safeguarding training this will be scheduled to be completed on their return from LT sick leave A full audit of residents care plans was carried out 01/08/2024, actions from this will be addressed by 31/08/2024.	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/12/2024
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	31/12/2024
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Substantially Compliant	Yellow	31/12/2024

	training, including refresher training, as part of a continuous professional development programme.			
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.	Substantially Compliant	Yellow	31/12/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/12/2024
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2024
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.	Substantially Compliant	Yellow	31/12/2024
Regulation 23(1)(c)	The registered provider shall	Substantially Compliant	Yellow	30/09/2024

	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.			
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Substantially Compliant	Yellow	30/09/2024
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or	Substantially Compliant	Yellow	08/08/2024

	environmental restraint was used.			
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.	Substantially Compliant	Yellow	31/08/2024
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/12/2024
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/12/2024
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the	Substantially Compliant	Yellow	31/08/2024

	designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).			
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 supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	31/08/2024
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	31/08/2024
Regulation 05(6)(b)	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	Substantially Compliant	Yellow	31/08/2024

	circumstances, which review shall be conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
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.	Substantially Compliant	Yellow	31/08/2024
Regulation 05(6)(d)	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 take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	31/08/2024
Regulation 08(6)	The person in	Substantially	Yellow	31/08/2024

	charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Compliant		
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.	Substantially Compliant	Yellow	31/08/2024