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:	Ballybrack
Name of provider:	St John of God Community Services CLG
Address of centre:	Co. Dublin
Type of inspection:	Announced
Date of inspection:	27 June 2024
Centre ID:	OSV-0002884
Fieldwork ID:	MON-0035366

About the designated centre

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

Ballybrack designated centre operated by St John of God Community Services Company Limited by Guarantee consisting of two residential community houses both located in South County Dublin. The designated centre intends to meet the specific care and support needs of adults with an intellectual disability. Residents in Ballybrack designated centre require low to medium assistance with their care and support needs. Residents health needs are monitored by a GP of their choice and they are supported by staff to attend medical check-ups as required. One residential house can accommodate up to six residents while the other residential house can accommodate up to four residents. One of the houses caters for males only, the other residence caters for both male and female residents. Residents are supported to travel independently and have access to transport provided by St John of God Services, either through sharing with other locations or with a vehicle assigned to the location. The centre is managed by a person in charge who is supported in their role by a social care leader. The staff team is made up of social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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 27 June 2024	09:30hrs to 18:15hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

The inspector found that the provider and person in charge were endeavouring to ensure that the wellbeing and welfare of residents living in the centre was maintained by a good standard of evidence based care. Residents who spoke with the inspector advised that they enjoyed living in their home and that they were happy with the support provided by staff. However, there were compatibility issues in the centre which, at times, led to safeguarding concerns, and which impacted negatively on the lived experience of residents residing in one of the houses.

The inspector used observations and discussions with a number of residents alongside a review of documentation and conversations with key staff and management to inform judgments on the residents' quality of life.

The centre was comprised of two separate community houses. One residential house can accommodate up to six residents while the other residential house can accommodate up to four residents. One of the houses caters for males only, the other residence caters for both male and female adults. All residents were provided with their own bedrooms and in each house there was a kitchen, dining area and sitting room. Both houses include toilet and shower facilities upstairs and downstairs. Most of the residents' bedrooms were upstairs however, in one house there were two bedrooms downstairs and in one house, one downstairs bedroom.

On walking around the first house the inspector observed that, for the most part, the house was clean and tidy and in good upkeep and repair. However, many of the walls were bare and lacked a homely feel to it. On speaking with the person in charge, the inspector was informed that this was not in response to the needs' or preferences of residents, but that there were plans to review the décor to make the house more homely.

The inspector met two residents in this house. One resident was happy to show the inspector their room and talked about their lived experience in their home. While the resident said they were happy living in the house and were happy with the support provided from staff, the seemed to find it difficult when asked if they liked the people who they shared their home with.

The inspector also met another resident who had just returned from a stay in hospital. The resident was taking the week off from their day-service until they fully recovered. The resident told the inspector that they were happy and liked living in their home. The inspector observed the person in charge support the resident make their breakfast. The inspector saw that the resident was provided choice and that their independence was promoted throughout the preparation of their breakfast. Overall, the inspector observed that staff and management were respectful towards residents through positive, mindful and caring interactions.

In the second house, the inspector observed, that overall, the house was clean and

tidy and provided a cosy and homely atmosphere. However, there were a number of upkeep and repair works needed to areas of the house and in some areas, a deep clean was observed to be needed. New flooring had been laid on the ground floor as well as renovations to an upstairs bathroom, which provided better accessibility for residents in the house. The sitting room and dining area were large and spacious and observed to be provide a warm and relaxing environment.

The inspector met four residents living in this house and was provided the opportunity to sit and speak with them for a while. Most residents had attended their day-service that day however, one resident was supported to attend a healthcare appointment with their staff. The residents told the inspector that they were happy with who they shared their home with. They said they were happy with the support from staff and that they liked their rooms and the house overall. Later in the day the inspector observed residents sitting at the dining table enjoying an arts and craft project; residents appeared happy and content in the company of staff while working on the project.

One resident told the inspector of how they were supported access their bedroom which was upstairs. The resident said that they were afraid they would fall if they walked up and down the stairs independently. Later in the day the inspector observed a staff member support the resident in accessing their room; In line with the safety protocol in place, the staff member walked in front of the resident when they were going upstairs and again when they were going downstairs. While this ensured the safety of the resident accessing their room, the location of the resident's bedroom was impacted negatively on them being able to independently access their bedroom.

One resident lived in an apartment that was attached to the house. Overall, the inspector observed the apartment to by clean and tidy and laid out in a way that met the resident's needs and preferences. The resident was happy to speak with the inspector in their sitting room. They had just returned from their day-service and were watching a tennis match on the television which they appeared to be really interested in. The resident told the inspector that they were happy living in their apartment.

Communal spaces such as the kitchen and dining room included ample information posters and notice boards that were part of residents' everyday life in the house and as such made it more individual to them. For example, easy-to-read menu and activity plans, picture-format rosters of staff on duty, complaints procedures, notices about the HIQA inspection, but to mention a few.

All houses provided residents with a garden. In one house there was an accessible garden with garden furniture and a shed. However, in the other house, while there was a big garden out the back, the inspector observed that much of it was not as accessible as it could be. There were steps to access the back garden which partially hindered the promotion of accessibility for some residents. One resident told the inspector that they did not use the back garden as they were afraid they might fall. The area just outside the back door behind the path was covered over in overgrown shrubs and bushes. There was a large grass area to the other side with a seating

area further back however, independent access to it was limited for some residents as there was no pathway to that area. There had been a plan to upgrade the garden area for a number of years however, as of the day of the inspection there was little traction of the plan.

In advance of the inspection, residents were each provided with a Health Information and Quality Authority (HIQA) survey. Eight out of nine residents chose to complete the surveys. All nine residents were supported by their staff when completing the surveys. Overall, the surveys relayed positive feedback regarding the quality of care and support provided to residents living in the centre. There was positive feedback regarding living in the centre, for example, residents ticked on the survey that the centre was a nice place to live in and that they liked the food and had their own bedroom. Residents were also positive about their day to day choices and ticked that they felt safe in their home, were provided privacy when making calls, had money to spend .

The surveys also demonstrated that, residents' felt staff knew what was important to them and were familiar with each of their likes and dislikes. They ticked that staff provided help to them when they needed it. Most residents noted that they felt listened to and were included in decision making in their home and overall, were kept informed about new things happening in the centre and in their life.

Where surveys asked residents if they the liked who they lived with, some of the responses included the following, One resident noted that they didn't like when their housemate walked into their room without asking. One residents stated that they felt they are only friends with one person in their home. One resident advised that they would like to live with their family member.

Residents were consulted and involved in the running of their home. Residents were provided with household meetings to discuss matters that were important to them as a resident living in the house. On review of a sample of recent resident meeting minutes, the inspector saw that each resident's photograph was included on the agenda and ticked to not if they attended or not. Items such as housekeeping, service news and developments, complaints, infection and control, for example information on hand-hygiene the staff requirement to wear face masks in recent weeks, were discussed.

In summary, the inspector found that the person in charge and staff were striving to ensure that residents' well-being and welfare was maintained to a good standard and that a person-centred culture was promoted within the designated centre. However, due to on-going compatibility issues in one of the houses, improvements were needed to ensure that the centre was safe and met the needs of all residents, at all times.

In addition, there were a number of improvements needed to the governance and management systems in place, medication management arrangements, positive behavioural supports, staff training and premises, to ensure the service being delivered to each resident living in the centre ensured positive outcomes and a positive lived experience.

Capacity and capability

This was an announced inspection. The purpose of the inspection was to inform a registration renewal recommendation for the designated centre.

The management systems in place had not adequately ensured that the service provided was safe, appropriate to all residents' needs and effectively monitored, at all times. While there had been some improvements since the last inspection, overall this inspection found an increase of non-compliance compared to the last inspection in January 2023. In particular, in relation to positive behavioural supports, protection, medication and training and development.

As such, the inspector found that the provider was not operating in a manner that ensured all residents living in the centre were safe or in receipt of adequate supports to meet their assessed needs. Overall, this situation was impacting negatively on the lived experience of a number of residents living in the centre.

There were a number of governance and management monitoring systems in place in the centre; these included provider led audits, quality improvement plans, local checklist systems and peer to peer audits, but to mention a few. However, the inspector found that not all audits had taken place as scheduled or were an effective tool in promoting quality improvements; On review of the last two unannounced six monthly reviews of the quality care and support provided to residents, the inspector saw that deficits relating to medication management training had not been identified. In addition, a peer to peer medication management audit had also not identified the training issue.

There were a number of local audits and checking systems in place in the house to ensure the safety of residents. However, there were a number of gaps in the audits relating fire safety, infection prevention and control, and training and development which impacted on their effectiveness in ensuring positive outcomes for residents.

For the most part, there were clear lines of accountability at individual, team and organisational level so that, staff working in the centre were aware of their responsibilities and who they were accountable to. However, the role of frontline supervisor (team leader), which is an integral role in supporting the local governance and management structures and systems in place, was vacant for the past two months. During this period, there had been a change to a number of procedures in place in and in particular, relating to the reduction in oversight of team meetings and frequency of staff supervision meetings.

A new person in charge had commenced in their role in May 2024. The person in charge was familiar to the service as they had previously managed the centre. On commencing their role, the person in charge carried out a baseline audit of all areas of service provided in the centre; This was to evaluate and improve the provision of service and to achieve better outcomes for residents. A number of the deficits,

found on this inspection, were identified on the audit however, many of the actions had yet to be implemented.

Improvements were needed to ensure that there were effective information governance arrangements in place to ensure that the designated centre complied with notification submission requirements at all times. The person in charge was endeavouring to ensure that all adverse incidents and accidents in the designated centre, were notified and within the required time-frame. However, not all restrictive practices, that had been in place in the centre, were identified or notified to the Chief Inspector on a quarterly basis.

There was a staff roster in place and overall, it was maintained appropriately. The registered provider was striving to ensure that the number, qualification and skill-mix of staff was appropriate to the number and assessed needs of residents, the statement of purpose and the size and layout of the designated centre. There were two staff vacancies in the centre. While the person in charge was endeavouring to provide continuity of care, in one house, there had a been a recent increase in the reliance on agency staff due to high levels of staff sick leave.

There was a system in place to evaluate staff training needs and to ensure that adequate training levels were maintained. However, the inspector found that the system was not effective as there was a high level of staff refresher training overdue for a long period of time.

There was a schedule in place for one to one staff supervision meetings for the year of 2024. In line with the provider's policy, staff were due to be provided supervision four times as year. However, no staff had received a meeting during the first quarter of 2024.

The inspector found that the provider was endeavouring to ensure that the policies and procedures were consistent with relevant legislation, professional guidance and international best practices. They were written for the service and were clear, transparent and easily accessible.

Registration Regulation 5: Application for registration or renewal of registration

The application for registration renewal and all required information was submitted to the Office of the Chief Inspector within the required time-frame.

Judgment: Compliant

Regulation 14: Persons in charge

There was a new person in charge in the centre. They were also responsible for one

other designated centre which consisted of three houses. The governance structure in place in the centre included a frontline supervisor (team leader) to support the person in charge in assisting them with the operational oversight of the centre.

Through a review of documentation submitted to the Health Information and Quality Authority, (HIQA), the inspector found that the person in charge had the appropriate qualifications and skills and sufficient practice and management experience to oversee the residential service to meet its stated purpose, aims and objectives.

On speaking with the person in charge during the inspection, the inspector found that they were familiar with residents' support needs and were endeavouring to ensure that they were met in practice.

In addition, the inspector found that the person in charge had a clear understanding and vision of the service to be provided and, supported by the provider, fostered a culture that promoted the individual and collective rights of residents living in this centre.

Judgment: Compliant

Regulation 15: Staffing

There were two social care worker vacancies (whole time equivalent of 0.5 each) in the centre. The provider was endeavouring to recruit for the two staff vacancies however, had not been successful in filling the positions to date. There was also a frontline supervisor (team leader) vacancy in the centre, however, the inspector was informed that the position had been filled and the person was due to commence their role at the beginning of July 2024.

The provider had identified the compatibility issues in of the one houses within the designated centre. In response to this the provider had reviewed staffing arrangements, and in line with safeguarding plans and risk assessments, increased staffing levels so that there was double cover during Monday to Thursday. For example, to support lone working staff, an additional staff member was employed during these evenings. Residents would often spend weekends at home with their family, but where residents chose to stay in the centre at the weekend, a level of double cover was also arranged during these times.

While vacancies had primarily been covered by the organisation's relief team, the roster for one house demonstrated, that in the past three weeks there had been a heavy reliance on agency staff. The person in charge was endeavouring to employ the same agency staff as much as possible and over a number of days side by side. However, as this could not always be achieved it meant that continuity of care could not always be ensured. This posed a potential risk to the consistent implementation of behavioural support strategies and overall, to the safety of residents living in this house.

Judgment: Substantially compliant

Regulation 16: Training and staff development

On review of the training schedule, the inspector found that the organisation's mandatory education and training courses available to staff had the potential to enable staff to provide care that reflected up-to-date, evidence-based practice.

However, the inspector found that the training needs of all staff were not effectively monitored and addressed in a timely manner and as such potentially impacted on the delivery of quality, safe and effective services for residents.

On a review of the training matrix, the inspector found that, not all staff had been provided with refresher courses of the organisation's mandatory training. A lot of staff training was out of date and as such posed a potential risk to the quality of practice in place.

For example, on review of the training matrix the inspector saw that four staff had not received safe medicine management training, two of the staff were due refresher training twelve months ago. In addition, dysphagia training was out of date for four staff members and positive behavioural support training was overdue for staff who had completed the training in 2021 and 2022. Furthermore one staff was overdue fire safety training since July 2023 and safeguarding training since November 2023.

Dementia and epilepsy training, to support staff meet the assessed needs of residents, was required to be provided for most of the staff team and a course and date had yet to be organised.

The inspector reviewed the supervision schedule in place and saw that supervision and performance appraisal meetings, to support staff perform their duties to the best of their ability, had not been provided to the majority of staff, as scheduled for quarter one. The new person in charge had just recently completed a number of the quarter two scheduled meetings with staff in June 2024.

Judgment: Not compliant

Regulation 19: Directory of residents

The registered provider had established and maintained a directory of residents in the designated centre. The directory had elements of the information specified in paragraph three of schedule three of the regulations.

Judgment: Compliant

Regulation 21: Records

On the day of the inspection, records required and requested were made available to the inspector.

On the day of the inspection, the person participating in management organised with for staff records to be made available to the inspector for review.

A sample of nine staff files (records), were reviewed and the inspector found that they contained all the required information as per Schedule 2.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had valid insurance cover for the centre, in line with the requirements of the regulation.

The service was adequately insured in the event of an accident or incident. The required documentation in relation to insurance was submitted as part of the application to renew the registration of the centre.

The inspector reviewed the insurance submitted to HIQA and found that it ensured that the building and all contents, including residents' property, were appropriately insured. In addition, the insurance in place also covered against risks in the centre, including injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

Overall, the inspector found that the provider had not ensured, that satisfactory management and oversight arrangements, to ensure a good quality service for residents, were in place at all times. As a result, a number of non-compliances were found on this inspection.

The provider had completed an annual review to assess the quality of care and support provided in the service between March 2023 to March 2024 and a copy had been submitted to HIQA in advance of the inspection. The review demonstrated that

residents and where appropriate, family, had been consulted in the process.

In addition, the provider had completed, as required, two six monthly unannounced reviews of the quality of care and support provided to residents living in the centre in November 2023 and April 2024 which included action plans and timelines.

However, on review of the six monthly review the inspector saw that they had not been fully effective in identifying all areas for improvements. For example, out of date training, fire drill issues that had not been followed up, gaps in the review section of behavioural and incident logs and lack of implementation of behavioural support reactive strategies, but to mention a few.

There was a schedule of local audits for the person in charge to carry out to ensure that the service being provided was safe and appropriate to the needs of residents. However, on review of the schedule there were a number of gaps for the first quarter of 2023. From May 2024 onwards, improve had occurred and monthly audits were on target as per the schedule.

The provider had not completed renovation works to one of the centre's premises within the timeframe provided on their last compliance plan. The provider was not adhering to best practice in achieving and promoting accessibility. This was impacting negatively on the promotion of residents' independence as well as their safety, health and wellbeing, in terms of infection prevention and control. The provider had completed some works in the house to reduce the level of infection prevention control risk however, on the day of the inspection there were other upkeep and repair works identified which meant that the potential risk was still present.

The governance and management systems in place to ensure that there was safe medication management systems in place was not effective. For example, a peer to peer medication management audit had identified a number deficits in safe medication management. Most of the actions from the audit had been completed, however, the audit had failed to identify practices that were not in line with the provider's policy. For example, staff administering medication when their training was out of date.

While the provider had been made aware about on-going compatibility issues in one of the houses in the centre since 2022, the timeliness to find an adequate solution to reduce the risk of ongoing incidents was not satisfactory. This meant that residents' safety was not ensured at all times and overall, was impacting on the lived experience of residents in their home.

In addition, on review of the infection prevention control audit that was carried out in May 2024, the inspector found that the audit was not effective in identifying a number of the issues found on the day of the inspection. For example, the audit failed to identify that the water outlet checklist in one of the houses had not been completed from January to March 2024.

The inspector reviewed the minutes of two team meetings which took place in May and June 2024. No management had attended the meetings. The current procedure

in place was for staff to hold their own meetings and escalate any actions required to the person in charge. However, on review of the minutes the inspector saw that there was limited details in minutes of meetings. For example, for the most part, there was no information under any of the headed sections such as actions, person responsible for actions and timeframe. This meant that staff who did not attend the meeting, were provided limited information on what was discussed, what action was needed, who was responsible and what were the timelines in place.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had submitted a statement of purpose which accurately outlined the service provided and met the requirements of the regulations.

The inspector reviewed the statement of purpose and found that it described the model of care and support delivered to residents in the service and the day-to-day operation of the designated centre.

In addition, a walk around of the property confirmed that the statement of purpose accurately described the facilities available including room function.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had ensured that all adverse incidents and accidents in the designated centre, required to be notified to the Chief Inspector, had been notified and overall, within the required timeframes.

In relation to deficits regarding notifying restrictive practices, this has been addressed under regulation 7.

On review of the centre's behavioural and incident logs (that included adverse events), the inspector saw that there were a lot of gaps; for example, there were not completed sections that required input about the completion of the review and comments regarding the review. This meant that provider could not be assured that shared learning occurred after each incident.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The person in charge had ensured that complaints' procedures and protocols were evident and appropriately displayed and available to residents and families in each of the houses in the designated centre.

The registered provider had established a system to address and resolve issues raised by residents or their representatives. Systems were in place, including an advocacy service, to ensure residents had access to information which would support and encourage them express any concerns they may have.

The inspector was advised that there had been a number of complaints from families of residents regarding the impact of the compatibility issues in the house on their family members. However, on review of the associated documentation, the inspector saw that while complaints had been followed up, there was no adequate documentation available to the inspector, or the person in charge, that clearly demonstrated the resolution or the satisfaction levels of the persons making the complaints. This meant that the provider could not be assured that the practice in place was in line with the provider's policy and procedures.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

There were relevant policies and procedures in place in the centre which were an important part of the governance and management systems to ensure safe and effective care was provided to residents including, guiding staff in delivering safe and appropriate care.

On a review of the centre's Schedule 5 policies, the inspector found that all policies and procedures had been reviewed in line with the regulatory requirement.

As such, the register provider had ensured that that all policies and procedures were consistent with relevant legislation, professional guidance and international best practice relating to delivering a safe and quality service.

Judgment: Compliant

Quality and safety

The provider and person in charge were endeavouring to ensure that residents'

wellbeing and welfare was maintained to a good standard. The person in charge and staff were aware of residents' needs and for the most part, were knowledgeable in the care practices to meet those needs. However, there were a number of improvements needed in the centre to ensure positive outcomes for all residents. In particular, in one house, due to ongoing compatibility issues, the lived experience of residents was not always positive. In addition, to ensure the safety of all residents, improvements were needed to the area of safe medicine management and behavioural support arrangements in place.

Although the provider was endeavouring to reduce the increase of behavioural incidents occurring in one house within the centre, the overall impact of the incidents was impacting on residents in a negative way. There had been a high number of behavioural and safeguarding incidents occur since the last inspection.

The organisation's safeguarding policies and procedures had been reviewed and updated in April 2024 and the majority of staff had been provided with training in safeguarding and protection of vulnerable adults. Where safeguarding incidents had occurred in the centre, the person in charge had followed up appropriately and ensured that they were reviewed, screened, and reported in accordance with national policy and regulatory requirements. However, due to on-going compatibility issues in the house, in terms of safeguarding, residents were not protected by practices that promoted their safety at all times. While a number of restrictive practices had been put in place in an attempt to keep residents safe it had in turn, resulted in residents living in an environment that was restrictive in nature.

The inspector reviewed the arrangements in place to support residents' positive behaviour support needs. The provider and person in charge promoted a positive approach in responding to behaviours that challenge however, significant improvement was needed to ensure that evidence-based specialist and therapeutic interventions were fully implemented at all times.

There were a number of restrictive practices in place in the centre. Where applied, the restrictive practices were clearly documented and were subject to review by the appropriate professionals involved in the assessment and interventions with the individual. For the most part, the restrictive practices were supported by appropriate risk assessments which were reviewed on a regular basis. However, not all recently implemented restrictive practices had been applied in line the organisation's or national policy on restraint and evidence-based practice.

The premises comprised of two houses that were centrally located in a community with access to local amenities, services and public transport which supported residents' autonomy to engage and connect with their local community.

In one house, improvements were needed to the décor so that it provided a more homely atmosphere. The other house was observed to have a homely and relaxing environment for residents to enjoy. However, a planned renovation to improve infection prevention control deficits as well as planned renovations to better promote accessibly, had not taken place.

Individual and location risk assessments were in place to ensure that safe care and

support was provided to residents. The risk register had been recently reviewed and updated. However, improvements were required to the register and assessment to ensure that control measures for all presenting risks, in particular, those relating to safe management of medication, were adequately included.

A staff member showed the inspector the layout of the medication cupboards and systems in place. Overall, the staff member was knowledgeable of safe medicine management practices.

However, not all staff had been provided appropriate refresher training in the safe administration of medicine or within a timely manner or in line with the provider's policy. This meant that there was a potential risk of practices relating to the administration, storing and recording of residents' medication not been satisfactory or safe at all times.

Residents were provided with an individualised personal plan that included an assessment of their health, personal and social care needs. There were care plans in place that included information on how to support each residents' needs. However, on review of a sample of plans the inspector found that there were a number of gaps within the plans.

They were adequate fire containment and fire detection systems in place. There was also satisfactory emergency lighting and fire-fighting equipment in the centre. These were all subject to regular checks and servicing by an external fire company.

Local fire safety checks took place regularly and for the most part, were recorded appropriately. However, where residents had been assessed to require specific fire safety support equipment, improvements were needed to ensure that the equipment was always in place as well as a satisfactory checking system in place for them.

Fire drills were being completed by staff and residents, which simulated both day and night time conditions. However, improvements were needed to ensure that where issues were identified during drills, that they were followed up in a timely manner.

Regulation 17: Premises

On a walk around of all two houses the inspector observed them to appear tidy, and for many of the areas, clean. However, there were a number of improvements needed to the upkeep, repair and cleanliness of number of areas of one of the houses. For example;

The walls in the hall were observed to have cracks and marks and required upkeep and painting.

There was a hole in the wall near the light switch for the bathroom. This issue had been raised at residents' meetings on two occasions however, not action had been

completed.

The kitchen units and counter appeared worn and run down with some areas observed to have water damage and blistering. The tiling grout around the kitchen units was observed to be chipped and required a deep clean in some areas.

The carpet on the stairs appeared worn with black ingrained marks on many of the steps.

There was a lot of chipped paint observed in one of the staff bedrooms.

A radiator in one of the bathrooms was observed to have a lot of rust on the base of it.

Subsequent to the last inspection, the provider submitted assurances to bring regulation 17, premises, back into compliance by June 2024. This was to mitigate a number of infection prevention and control risks as well as promoting accessibility for residents changing mobility needs. At the time of the last inspection, the provider was finding it difficult to source alternative accommodation for residents to temporarily stay in during the renovation. The inspector found that the same difficulty remained in place for this inspection.

Notwithstanding the above, there had been some upkeep and repair work completed since the last inspection. For example, in one house an upstairs shower had been renovated and included an accessible shower with chair. The downstairs flooring upgrade (outstanding since November 2021), was completed in May 2023. The new flooring meant that there was better accessibility for residents moving in and out of the hall, kitchen, sitting room and dining room. It also reduced the previous infection prevention and control risk as it could now be effectively cleaned.

However, works on the garden area out the back of the house, to be completed by May 2022, remained outstanding. An inspection in the centre in August 2021, had identified that the garden area to the rear of the property did not provide residents with an entirely accessible space as some areas posed a potential fall/trip hazard. A space in the rear garden with garden furniture was only accessible through an uneven grassy area and therefore not all residents could independently access this without staff support.

In addition, the changing mobility needs of some residents meant it was difficult accessing the stairs to their bedroom as independently as they were previously able to. For example, one resident required the support of a staff member when going up and down the stairs. While this ensured the resident's safety and reduced the risk of falls and injury, it meant that the layout of the house, was impacting on the promotion of their rights and in particular, right to dignity and independence.

Overall, the inspector found that the timeliness of the full renovation works was not satisfactory and was resulting in residents living in a house where some of the internal and external spaces were not to the optimal standard or fully meeting residents' assessed needs. Overall, the deficits relating to the internal and external spaces in the house were not adhering to best practice in achieving or promoting

accessibility for residents living in the centre.

Judgment: Not compliant

Regulation 20: Information for residents

The registered provider had prepared a guide for residents which met the requirements of regulation 20. For example, on review of the guide, the inspector saw that information in the residents' guide aligned with the requirements of associated regulations, specifically the statement of purpose, residents' rights, communication, visits, admissions and contract for the provision of services, and the complaints procedure.

The guide was written in easy to read language and was located in an accessible place in the designated centre; There was a copy of the residents' guide available to everyone in the house.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had ensured that the risk management policy met the requirements as set out in the regulations.

There was a risk register specific to the centre, and for the most part, it addressed individual and centre risks. The risk register had recently been reviewed and updated in May 2024.

The person in charge had completed a range of risk assessments, which for the most part, included appropriate control measures to mitigate or reduce the potential risks.

However, in relation to the risk assessment regarding safe administration of medicines, a review was warranted to ensure it was appropriately risk rate and it included all addition control measures in place.

Judgment: Substantially compliant

Regulation 27: Protection against infection

While there had been some upkeep and repair improvements, such a new flooring

and bathroom in one house, improvements were needed to ensure other upkeep and repair issues that were observed on the day were addressed and within a timely manner.

For example, so of the deficits identified on the day included;

In one house, a two seater leather couch in the relaxation room was observed to be badly worn and with a lot of cracks and scrapes on the seating.

A resident's bedroom mattress was observed as unclean, the mat at the bed and floor area were also observed to be unclean.

In the other house, there was no cleaning check in place for residents' mobility equipment including shower facility mobility equipment. This meant that there was no adequate system in place to monitor the cleaning of the equipment to ensure residents' health and safety when using it. It also meant that the provider could not be assured that the equipment was being cleaned in line with the manufacture's instructions and safe to use.

In the kitchen in the attached apartment, the washing machine appeared dirty on the outside and inside.

The inspector was informed that the water outlets were never in use however, there had been no water checks from January 2024 to March 2024 to ensure the safety of the water.

The inside of the windows in two bedrooms were observed to have black grime which appeared to be mould. Some of the grime was also observed on the inside rubber seal on the window.

Overall, a lot of the upkeep and repair meant that the areas could not be effectively cleaned in terms of infection prevention and control and as such, posed a risk of the spread of healthcare-associated infection to residents and staff.

Some of the above deficits had been identified in a recent audit completed in May 2024 however, some had also been identified on the last HIQA in January 2023.

Judgment: Substantially compliant

Regulation 28: Fire precautions

A fire drill carried out in October 2023 identified an issue that impacted on the timeliness of two residents evacuating their home, in the case of fire. The inspector found no documentation in place to demonstrate appropriate follow-up subsequent for the identified risk. Overall, the timeliness to address this risk was not satisfactory and put residents at an unnecessary risk.

However, in May 2024 a baseline audit completed by the person in charge, identified the issue and after providing clinical support, a follow up drill saw the resident evacuate in a timely manner.

For the other resident, a vibrating pillow to support with hearing difficulties, had been recommended by an allied healthcare professional to enable them wake up from a deep sleep in the event of a fire. However, it was recently identified that the pillow had not been in place since 2022. This impacted negatively on the safety of the resident in the event of a fire.

While there were a number of daily, weekly and monthly fire checks in place in the centre, this equipment (vibrating pillow), that was linked up to the fire alarm had not been included in the checks. An interim evacuation plan has since been put in place whereby a staff member now alerts the resident of a the alarm and safely supports them out of the building. Overall, this situation was negatively impacting on the resident's right to evacuation the building independently was likely to remain in place until the equipment was re-instated.

Notwithstanding the above, for the most part, the centre had put in place fire management systems which endeavoured to ensure residents' safety. These included containment systems such as fire doors, fire detection systems, emergency lighting, and fire fighting equipment. They were all subject to regular checks and servicing by an external company.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Not all residents' health and wellbeing was supported by the residential service's policies and procedures for medication management.

Four staff had not completed refresher training in safe management of medicine training. The next available training was in August 2024. On the day of the inspection, the inspector found that three staff, (including lone working staff), whose safe medication management training was out of date, were continuing to administer medication to residents. This meant that staff practice was not current or reflected up-to-date, evidence-based practice. There also was a risk to the quality of care and support provided to residents and of their medication not being administered correctly. On review of training records, the inspector saw that for two staff, the training was twelve months out of date.

While there had been a low level of medication errors during the period, a medication audit that was completed in May 2024 found a number of deficits in one house regarding safe medication management practices. For example, not all residents' administration charts were in date. Returned medicines and regular and PRN medications, (medicine taken when required), were inadequately stored. A number of medicines were not provided with an 'open date' label on them. There

were gaps in signage, not all PRN medicines were in stock and not all administration charts had been marked on days where residents were away from house. In addition, on the day of the inspection, the person in charge had identified a gap in the signature for one set of administered medicines.

The May 2024 audit clearly demonstrated that areas of safe medicine management practices required improvement. It also potentially indicated the impact of the lack of refresher training and inadequate oversight and monitoring of safe administration of medicines.

In response to this, the provider initiated for some staff to complete an assessment on 25th of June 2024. The assessment entailed a senior nurse manager observing the staff member carry out administration of medicines as part of a knowledge-checking system. This provided a level of assurance to the provider of the competency, skill and knowledge of the staff member however, the timeliness of implementing the assessment was not satisfactory. In addition, the assessment had not been provided to all staff who's refresher training was out of date.

On day of inspection, when the inspector raised the urgency of the risk, the person in charge ensured that additional actions were implemented to further reduce any potential risks. For example, the person in charge implemented a new procedure for copies of all administration of medication records to be scanned and sent to them for review twice daily. Should any incidents or queries be identified, they were to be dealt with promptly by the person in charge.

The procedure also included that, where an unusual medication task runs a higher than usual risk of error, such as discharge from hospital, the person in charge would oversee the process of handover, ensuring correct documents were in place and sighed as required.

By the end of the inspection, the person in charge advised the inspector that a clinical assessment for the second staff member would take place on July 7th and other on the 10th of July.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

On review of a sample of residents' personal plans, the inspector found that not all reviews of the plans were effective or were carried out on an annual basis. In addition, the content in a number of residents' personal plans was not representative of what was current in the residents' lives.

A number of gaps had been identified by the person in charge in a base-line audit of service provision in May 2024. The audit identified a number of gaps and improvements required to residents' personal plans. For example, some healthcare charts had not been completed in a consistent manner, manager signatures were

required on a number of documents, for example, self-medication assessments. Personal evacuation plans required updating, a number of support plans had not been reviewed in a timely manner and financial passports were overdue review.

Notwithstanding the above, subsequent to the audit, the person in charge drew up an action plan, that included all improvements and updates required for each resident's personal plan.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Where appropriate, residents were provided with positive behaviour support plans, which were informed by an appropriate professional and comprehensively guided staff in the delivery of care. For the most part, plans were reviewed on a regular basis and updated appropriately. However, not all plans included sufficient detail of reviews that had taken place. For example, one plan noted a review was due in February 2024 however, details of review and of matters discussed or recommended, had not been included in the resident's plan.

On review of another positive behavioural support plan, the inspector saw that the review included an analysis of a resident behaviours over the past fourteen months; Overall, 101 behavioural incidents had occurred, 75 of these has occurred in the designated centre. The behaviours included physical aggression, inappropriate touch, aggression towards furniture and self-injurious behaviours.

The positive behavioural support plan also included an analysis of the implementation of reactive strategies. Overall, the analysis demonstrated that reactive strategies were not being implemented appropriately or at all. For example, for one behaviour, 100% of reactive strategies had not been implemented and for another behaviour, related to physical aggression, 78% of reactive strategies had not been implemented.

This meant that the behavioural support plan in place for the resident was not effective and negatively impacted on the potential reduction or appropriate management of behaviours that challenged. As such there was an on-going risk to the residents safety as well as other residents safety in their home. In addition, on review of the centre's training records, the inspector saw that not all staff had been provided refresher training in positive behavioural supports.

In May 2024, there was a review carried out of the restrictive practices in place in the centre. The person in charge identified a number of restrictive practices that had not been submitted to the organisation's rights committed or notified to HIQA as required. However, improvements had been made and any identified restrictive practices were in process to be submitted to the organisation's rights committed and notified to HIQA as required. Overall, the previous deficit in this area meant that the provider was not ensuring that all restrictive practices in place in the centre were

the least restrictive, for the shortest duration.

Judgment: Not compliant

Regulation 8: Protection

From January 2023 to the day of the inspection, there had been sixteen safeguarding incidents occur in the residential centre. While there had been a slight decrease during 2023 for a period, safeguarding incidents continued to occur right into 2024 (seven in 2024 to date).

The inspector was informed that three family members had raised complaints about the compatibility issues in one of the houses (one resident has since moved to alternative accommodation); Overall, local management, staff (on behalf of residents), and family members had all raised concerns over the compatibly issues and the negative impact it was having on the lived experience of residents. On review of a number of emails going back as far as 2022, the inspector saw that residents said they were scared and afraid in their own home due to the behaviours of another resident.

On review of an analysis of incidents, the inspector saw that many of the physical aggression incidents were towards staff however, some were towards other residents. There were safeguarding plans in place which had resulted in a number of restrictive practices being implemented and in turn, meant that residents' home life, at times, was restrictive in nature. In addition, as mentioned above, reactive strategies, that endeavoured to reduce the number of incidents occurring were not being adequately implemented.

Overall, satisfactory assurances were not in place to demonstrate that residents were free from abuse at all times. The risk of on-going incidents occurring in the house remained and as such, residents safety was not always ensured.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Ballybrack OSV-0002884

Inspection ID: MON-0035366

Date of inspection: 27/06/2024

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 SCL commenced her role on 28-06-2024. The provider has an ongoing recruitment drive underway, which includes open days, public advertising, and social media advertising. This action will take up until 30-01-2025 to complete. In the meantime, a pool of familiar relief and agency staff are employed to cover various forms of leave.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The staff member who was overdue her refresher training in safeguarding and fire safety has completed both trainings since the inspection date. Two staff completed the positive behaviour support training on the 24th July and all remaining staff have been signed up to complete the intensive e-learning module with the Callan institute. For staff on the e-learning module the completion date is 15-09-2024. Three staff have been signed up for SAMS training on the 15th and 16th August. One staff member is waitlisted for this date, however, this staff member is not administering medication. HR are working on sourcing another date in Q.4 for this staff member should a cancellation not occur in August. The staff member will have completed her SAMS training by 30-10-2024 and will not administer medication in the meantime.	

All staff who are due refresher training in dysphagia have been signed up for dates between July 2024 and November 2024.

The HR department are sourcing additional epilepsy dates to support the staff in this DC. All staff working with individuals with epilepsy will have completed this training by 30-12-2024. There is no emergency epilepsy medication in this DC.

Provision of training in dementia has been raised with the dementia planning committee. Training will be organized for staff working with individuals with dementia by 30-12-2024.

11/12 staff have complete a round of supervision sessions with the PIC between June and July 2024. One staff member is scheduled for August due to leave and rostered hours. A schedule of supervisions has been devised to ensure all staff will have received their supervisions in line with policy by year end.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Learning from this inspection has been shared with the quality team who undertake the 6 monthly provider visits.

Medication training has been added to the medication audit template.

The PIC met with the housing association on 24-07-2024 to discuss the renovations and upkeep and repair concerns regarding one location, along with the overall accessibility of the location. Actions as noted under regulation 17.
An emergency 'Residential planning group' meeting was scheduled and completed on the 18th July 2024 in order to review the compatibility situation in one location. A potential property has been identified that may suit one individual. The property is currently unregistered and will require premises/fire works to bring it up to regulatory standards. Funding will be required for both the works and staffing required to open a new location.

A business case will be submitted to the HSE for additional staffing and the capital works by 30-08-2024.

In the meantime there is a plan in place to improve the lived experience of the individuals living in the location including;
• Implementation of restriction reduction plans
• Improving implementation of the BSP
• Improving staff training in relation to PBS and communication
• Improved oversight with the commencement of a new SCL

• A focus on person-centred planning through audit and review The SCL now attends team meetings with staff. Recording of actions, person responsible and timeframes is now recorded in a detailed manner to ensure staff not attending have sufficient information. The SCL escalates relevant concerns to the PIC and the PIC attends team meetings where required.

Regulation 31: Notification of incidents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: A system is in place to ensure all incidents are reviewed in line with policy. The new SCL inputs the incident onto the log (and in her absence the PIC undertakes this task). The SCL provides an initial aggregate review, which is then further reviewed by the PIC. Incidents rated moderate and above are reviewed by the Local incident management team. There have been no gaps since introduction of this system at the end of May 2024.	

Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The PIC maintains records of all complaints. A digital folder has been set up since the inspection to store all complaints documents, including the original complaint form, letters to the complainant, response letters, meeting minutes, and resolution letters. This will ensure that documentation regarding complaints is available to all who are required to access it and will provide for a streamlined handover process when changes do occur.	

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The PIC met with the housing association on 24-07-2024 to discuss the renovations and upkeep and repair concerns regarding one location, along with the overall accessibility of the property. Actions agreed as noted below;	

Internal communal area painting, to include skirtings, doors, ceilings and walls will be completed in one location by 30-12-2024.
The kitchen counter will be replaced, kitchen doors serviced and repaired, and a washable splashback fitted by 30-12-2024.
Carpets on the stairs and landing will be replaced with non slip flooring by 30-12-2024.
Two radiators will be replaced by 30-10-2024.
The overall renovation plan, to include the garden works, is planned to take place by December 2026. The renovation planned is envisaged to improve the lived experience of the individuals residing in the property and does not provide for an additional downstairs bedroom.
One individual who is predicted to require specific supports in the future has been identified as part of a larger organisational plan to provide additional dementia specific care in the community. This plan is envisaged to take approximately 24 months to come to fruition. Once in place, this will open up a downstairs bedroom for the individual who requires it and has clearly stated she does not wish to move locations in order to access a downstairs bedroom.
The current ramp in the garden will be cleared of overgrown shrubbery to ensure it provides safe and accessible access to the garden from the kitchen/diner. Additional overhanging shrubbery will be trimmed to ensure a portion of the garden can be set up as an outdoor seating space by 30-11-2024.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The medication risk assessment has been amended to include the additional assurances provided on the day of inspection and the rating has been upgraded to a red risk.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
A period of consultation has been undertaken with the individuals in one location and those that wished to be involved in the decision have chosen a new sofa from an online website. This will be in place in line with the inidividuals' preferences by 30-12-2024.
One individual's mattress, mat and chair which had been soiled on the day of inspection were replaced on the day. A second inidvidiual had a mattress which was identified as

requiring attention. This individual has an appointment booked with the GP to request a referral to a public health nurse for assessment of need in relation to requirements for a bed and mattress, given changing needs.
All individuals' mobility equipment is now detailed on the staff hygiene checklist.
The washing machine in the apartment has been cleaned since the inspection date.
Water checks in relation to the apartment are now in place and a system has been set up, such that the flush takes place during the team meeting, which ensures additional governance over consistency of completion.

All windows identified as requiring attention have been cleaned.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The vibrating pillow for one individual has been ordered, fire contractors have installed the relay switch, and the engineer is scheduled to link the device to the alarm on the 30th July 2024.

A procedure for use of the vibrating pillow has been devised, which includes a system for staff checks in relation to it's operation.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
All medications now have an opened on/discard by date noted on the label.
All PRN medications are now in stock.
Medication administration charts are all marked when the resident is away from the house.
All residents Medication administration charts are in date.
Medications for return to pharmacy have segregated storage.
All PRN medications are stored correctly.
All medication signage gaps have been followed up on.

All staff who are overdue their refresher training and continue to administer medication have received a clinical appraisal by a CNM2 and successfully passed this practical assessment.

Staff are currently sending their MARS charts to the PIC digitally for review. Additionally, the PIC is completing spot checks onsite of the MARS charts.

All staff, barring one are scheduled to complete their SAMS appraisal on the 15th and 16th August 2024. One staff member is on a priority waitlist for the 15th/16th training date, however, this staff member is not administering medications. Proactive scheduling is taking place to ensure there is no repeat of this risk, with two staff scheduled for October 2024, who will require refresher training by Q.1 2025.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All staff are currently working on the audit actions for each individual's personal plan. The SCL is scheduled to undertake a review of the audit actions in August 2024. The PIC is scheduled to commence re-auditing personal plans in October 2024 to ensure continued progress is occurring and a plan for the following months is documented.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The PIC has discussed PBS implementation at both staff supervisions and team meetings. All staff have re-read the BSP and a further team meeting has been scheduled to discuss the expectations in terms of reporting, and detail required in these reports, along with areas of low implementation.
The SCL will now review BRF's with the BSP beside her, so each incident can be assessed directly in line with the BSP.
The low-key tracking will now be reviewed monthly by the SCL and findings presented at the team meetings.

One individual's February review minutes have been sourced and are now maintained in her file.

Two staff have completed Positive behaviour support training on 24th July 2024. All remaining staff have been signed up for the intensive e-learning module. For staff on the e-learning module the completion date is 15-09-2024. 2 staff have also completed social

story training since the inspection date.

A reduction plan for one individual is being considered in relation to 1:1 supervision. The individual has been assessed by her physiotherapist since the inspection date, and a meeting has been scheduled with the PIC/SCL and physio to review the 1:1 supervision and consider the least restrictive options available to the resident.

A reduction plan is now in place in one location regarding access through then front door. All residents and staff now access the front door independently, and any concerns regarding behaviours are tracked and reviewed. To date this has been successful.

A local protocol is in place for each restrictive practice, referrals have been submitted to the Equality and Human Rights committee for any restrictions not previously submitted, and notifiables to HIQA have been completed for each restrictive practice in Q.2.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
An emergency 'Residential planning group' meeting was scheduled and completed on the 18th July 2024. A potential property has been identified that may suit one individual. The property is currently unregistered and will require premises/fire works to bring it up to regulatory standards. Funding will be required for both the works and staffing required to open a new location.

A business case will be submitted to the HSE for additional staffing and the capital works by 30-08-2024.

In the meantime there is a plan in place to improve the lived experience of the individuals living in the location including;
• Implementation of restriction reduction plans
• Improving implementation of the BSP
• Improving staff training in relation to PBS and communication supports
• Improved oversight with the commencement of a new SCL
• A focus on person-centred planning through audit and review

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	30/01/2025
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	30/01/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate	Not Compliant	Orange	30/12/2024

	training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/12/2024
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.	Not Compliant	Orange	30/12/2024
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Not Compliant	Orange	30/12/2026
Regulation 23(1)(c)	The registered provider shall ensure that management	Not Compliant	Orange	30/12/2024

	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 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	26/07/2024
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	30/12/2024
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where	Substantially Compliant	Yellow	30/08/2024

	necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.			
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	30/08/2024
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Not Compliant	Orange	30/10/2024
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the	Substantially Compliant	Yellow	26/07/2024

	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 environmental restraint was used.			
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	26/07/2024
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	30/12/2024
Regulation 07(1)	The person in charge shall	Substantially Compliant	Yellow	30/09/2024

	ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	30/07/2024
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	30/07/2024
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the	Not Compliant	Orange	30/07/2024

	least restrictive procedure, for the shortest duration necessary, is used.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/12/2024