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:	DC4
Name of provider:	St John of God Community Services CLG
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	27 June 2024
Centre ID:	OSV-0002936
Fieldwork ID:	MON-0034772

About the designated centre

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

St John of Kildare services - DC 4 is located on a campus based setting within walking distance of a large town in Co. Kildare with a number of local amenities. DC-4 is a congregated setting with all buildings and housing located on campus.
The designated centre is a large, purpose-built residential building divided into four units. The current capacity of the centre is 18 in line with the centre's de-congregation plan. DC 4 provides services to adults whose primary disability is intellectual disability. Residents may also have additional needs due to physical disability, sensory impairment, medical conditions and behaviours that challenge. Residents are supported on a full-time basis by a team of clinical nurse managers, nurses, social care workers and care assistants. Housekeeping staff also support the team.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17

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	10:10hrs to 17:40hrs	Erin Clarke	Lead
Thursday 27 June 2024	10:10hrs to 17:40hrs	Karen Leen	Support

What residents told us and what inspectors observed

A number of key areas were reviewed to determine if the care and support provided to residents was safe and effective. These included meeting residents and staff, reviewing personal plans, risk documentation, fire safety documentation, and documentation related to staff training. The majority of areas reviewed indicated that good levels of person-centered care were being afforded to residents. Some improvements were noted in fire safety, records, and assessment of need.

The inspection was announced following the registered provider's application to renew the registration of the centre. The centre is located on a large campus and is considered a congregated setting. The campus also accommodates other residential services, a school, adult day services, a swimming pool and administration buildings. The centre is a large purpose-built one-storey building split into four houses connected by interlinking corridors. Before 2018, the centre originally accommodated 26 residents, which had since been reduced to 18 residents due to the registered provider's de-congregation and transition of residents to community homes. The centre currently provides services to 17 male and female residents whose primary disability is an intellectual disability. The residents supported may also have additional needs such as physical disabilities, sensory impairment, medical conditions and behavioural support needs.

While the provider had plans to further de-congregate the centre in line with the national policy, *Time to move on from Congregated Settings*; at the time of the inspection, no further transitions had occurred. Notwithstanding, the centre was large, spacious and decorated to a good standard. The immediate impression of the centre was that it was very clean and well-kept, and efforts had been made to reduce the institutional aesthetic of the building. Flower pots had been planted and placed outside the front of the property, and there were four well-maintained gardens attached to each house. Plans had been made to re-purpose the number of empty bedrooms in the centre for areas for residents to enjoy such as small sitting rooms, an arts and crafts room and a sensory room. The person in charge informed the inspectors that while the centre was awaiting further decongregation, the residents' preferences and needs had been explored by staff to make the best use of the space in the centre.

The inspectors viewed the unused rooms in the centre. The project plan, timeline, photos, and actions for the future use of the rooms were attached to the doors of the rooms. One of these rooms included a multi-sensory room, which is due to be completed by September 2024. The project plan detailed the necessary works for installing a waterbed, sensory lights, a music and speaker system, seating arrangements, and lights. Another room was planned to be transformed into a beauty salon, providing residents with a space to relax and receive beauty treatments.

One room had been recently changed from a gym to a reading room, for one

resident in particular, as it was identified through their personal planning meeting that the resident had a great interest in reading and collecting magazines and reading materials.

In recent weeks, one kitchen and dining area in one part of the centre had undergone renovations so that meals could be prepared in the centre. The inspectors learned that home-cooked meals in the designated centre had become operational a few days before the inspection. Until now, meals had been provided primarily from a large industrial kitchen on campus and transported to each designated centre. Now, residents were able to smell and observe cooking and had an opportunity to experience preparing and cooking their own meals. On arrival at the centre, the inspectors could smell fresh food cooking, and the person in charge discussed plans to develop residents' skills and promote participation in meal preparation. Professional cooking staff had been appointed to the centre as part of the decentralisation of the campus kitchen, and the person in charge explained that it was still a work in progress to determine how residents would be supported in meal preparation in a professional cooking environment. Part of this plan included renovating an empty room for an area for residents to learn and implement cooking skills.

The inspectors 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. Effective communication was essential for all of the residents in this designated centre, as the majority of residents communicated without the use of words. The person in charge explained that communication assessments for residents were a priority for the service and were under review as part of the transition to a new system under the direction of a speech and language therapist.

There were a number of restrictive practices in use in the centre and these had been assessed for and reviewed by the provider when implemented. Restriction reduction and removal have also been evident since the previous inspection. A silent door alarm had been removed; one kitchen was open at all times. Another kitchen door was open for two hours a day. The practice of locking wardrobes had since ceased, and the front door to one house was opened during day hours.

Residents' bedrooms were decorated according to their personal preferences. Some bedrooms had panelled walls, large murals and plenty of personal possessions. For residents who preferred a more minimalist environment, this choice was also respected and implemented. The inspectors had the opportunity to meet with one resident who wished to show the inspectors their newly decorated bedroom. Staff assisted the resident to show the inspectors that their room had been completed with their favourite colours and some of their interests and hobbies. Support staff assisted the resident with communicating to inspectors that one of their past times was attending the local community for beautician appointments and hair appointments. The resident took great pride in showing the inspectors that their nails had recently been done and were attending an appointment later in the day to have them redone. On return from the beautician the resident returned to the

inspectors to show that their nails were done in a new colour.

One resident spoke to inspectors on their return from their day centre, the resident told one inspector that they had been completing some gardening with staff and that they had returned for lunch. The resident told the inspector that were just relaxing looking out to their garden area while staff got lunch ready. The resident told the inspector that the kitchen was nice. Support staff informed the inspector that the resident like to relax in their own sitting room prior to lunch and would then decide to eat in the dining room or with peers.

The inspectors met with one resident who was relaxing in a room in the centre dedicated to music. The inspectors observed the resident to move freely between the main sitting room and music room. The resident had access to accessible devices to change the music that was playing to music of their choice. The inspectors observed kind and warm interactions between the resident and staff. The resident was observed to communicate to staff through gestures and body language and the inspectors observed the support staff interpreting this communication to the satisfaction of the resident.

Residents had access to horticulture activities in the centre's polytunnel and herb garden. The inspectors learned of an innovative project in 2023, where residents started producing compost to reduce waste. This was expanded upon by partnering with four local businesses to collect coffee bean waste to improve the compost and make flower pots for family and business partners. The inspectors viewed photos of residents taking part in this project and growing fruit and vegetables for salads and smoothies.

A review of residents' records indicated that residents had meaningful lives and planned to achieve more goals in the coming year. Some residents attended on-campus day service programs, while other residents preferred to engage in activities from their homes. In-house activities included reflexology, music therapy, baking, watching movies, and working in the garden on the compost project. Some residents were visiting a waterfall during the inspection. Other residents had some hotel trips planned for later in the summer. Photos in the centre showed residents attending sporting events and meeting professional rugby players. One resident had a long-term goal of going on an aeroplane and had taken steps to achieve this goal, such as applying for a passport and visiting the airport to watch planes land. The resident had a flight booked to a regional airport in Ireland at a later date, and the resident was hopeful about going abroad if they enjoyed the experience.

As part of the provider's annual review for the centre, they sought the views of residents and family representatives about the services provided. Overall, this feedback was very positive. One family representative said staff were always very welcoming, pleasant and ''wonderful'' with the residents. They felt that their family member was happy, comfortable living in their home, and safe. Another family member explained they were always very satisfied with the care their family member has received throughout their time in the centre, and any concerns they had were dealt with swiftly.

Prior to the inspection, the residents, with the support of staff and their family representatives, completed questionnaires about whether they were happy with the services provided for review by the inspectors. Thirteen questionnaires had been completed by the resident with the support of family and three with the support of staff. On review of the completed questionnaires, all contained very positive feedback and commentary. Residents and families did not report or voice any concerns. Residents shared they were happy with the food provided, their rooms, and the level of choice they had in the centre. One resident said the quality of the environment was of a high standard. One family said they were happy to see environmental improvements happen in the centre. One of the questions related to safeguarding and feeling safe. One family answered they were aware of safeguarding plans in place to help keep their family member safe. One resident said it was important to their wellbeing that they had quiet time to relax on their way and explained they had their own personal sitting room to do so. One family member commented that familiar staff were always available to support their relative.

The next two sections of this report will present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being provided.

Capacity and capability

This was an announced inspection, completed to monitor the provider's compliance with the regulations and to inform the decision in relation to renewing the registration of the designated centre. The designated centre had previously been inspected in June 2022 under the infection, control and prevention standards, which were found compliant. The findings from the current inspection indicated that the centre was well-managed and generally in compliance with the regulations reviewed. There were various oversight strategies which were found to be effective both in relation to monitoring practices, and in quality improvement in various areas of care and support. Improvements found under the capacity and capability regulations related to record keeping of staff files, the accuracy of the submitted floor plans, and the centre's statement of purpose.

There had been a number of recent changes to the local management team. A new person in charge had commenced in their role in January 2024. The person in charge was very familiar with the service and the residents, having worked in the centre as a nurse manager for many years. The person in charge was full-time and they were supernumerary to the staff team. The person in charge was the clinical nurse manager (CNM2) of the service, who reported directly to a clinical nurse manager (CNM3) who held the role of a person participating in management (PPIM). The person in charge and local management team had systems in place for the day-to-day management and oversight of the centre. They were completing regular

audits and taking action to bring about improvements in relation to the residents care and support needs. These audits included the risk management process, medicine management, safety and protection, food and nutrition, infection control hygiene, and fire and safety.

The provider had ensured an annual report and six monthly internal audits had been completed as required by the regulations. The annual report for 2023 outlined the highlights for the residents, which included increased community exclusion and a reduction in restrictive practices used in the centre. The provider sought input from the residents and family representatives when compiling the annual report. Their feedback and comments were included in the overall report and reviewed by the inspectors during the inspection. Actions identified were documented as completed or ongoing to ensure effective and safe service provision to all residents in this designated centre.

The provider ensured that there were suitably qualified, competent and experienced staff on duty to meet residents' current assessed needs. The inspectors observed that the number and skill mix of staff contributed to positive outcomes for residents using the service. Warm, kind and caring interactions were observed between residents and staff.

The education and training provided to staff enabled them to provide care that reflected up to date, evidence-based practice. A supervision schedule and supervision records for all staff were maintained in the designated centre. There was a system in place to evaluate staff training needs and to ensure that adequate training levels were maintained. There were core training topics that staff had completed at their initial induction, and then there were training programmes that required refresher training at scheduled intervals. As per the centre's annual review, training and professional development was an area of focus in 2023. The inspectors found that staff had received a number of bespoke training sessions central to the care provided for residents in the designated centre. For example, the person in charge had organised psychology led training to further understand each individual in need of a positive behaviour support plan. The provider had also carried out person-centred and key worker workshops in order to enhance each residents lived experience in the centre.

The provider had submitted an application to renew the centre's registration for another three years. The application contained the required information set out under this regulation and the related schedules, such as insurance contracts, a statement of purpose, and the residents' guide. However, improvement was required, as listed below.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted a statement of purpose and floor plans as part of the application for registration renewal. Both documents required significant amendments to accurately reflect the service provided and meet the regulations'

requirements.

- The listed bedrooms did not have room numbers.
- Twelve rooms did not have the listed function of the room.
- There were discrepancies between the room functions, the floor plans and the statement of purpose.
- More detail was required regarding the specific support needs the centre can accommodate, the admission procedures, services to be provided, and personal planning.

In addition, the provider intended to register 18 bedrooms, but only 17 rooms were available for use as bedrooms because some rooms had been converted for leisure and communal space. The provider was asked to reassess the number of residents they intended to register based on the floor plans and statement of purpose.

Judgment: Not compliant

Registration Regulation 7: Changes to information supplied for registration purposes

The provider ensured that written notice was submitted to the Chief Inspector of Social Services as required to reflect a change in the centre's person in charge. All prescribed information for this notification was received within the required timeframes.

Judgment: Compliant

Regulation 14: Persons in charge

The provider had ensured that a competent person in charge had been appointed to work full-time and that they held the necessary skills and qualifications to carry out their role.

The person in charge demonstrated their knowledge of the regulations and accessed all documentation requested during the inspection by the inspectors in a timely manner.

The inspectors were informed and saw documented evidence of duties being delegated and shared, including audits, fire safety, staff supervision, and a review of personal plans among senior staff, key workers, and the person in charge.

Judgment: Compliant

Regulation 15: Staffing

On the day of the inspection the provider had ensured there was enough staff with the right skills, qualifications and experience to meet the assessed needs of residents at all times in line with the statement of purpose and size and layout of the building.

High levels of staff support were noted in the centre, and all staff appeared knowledgeable regarding the residents' individual preferences and needs when speaking with the inspectors. The staff team consists of clinical nurse managers (CNMs), social care leaders, nursing staff, social care staff, healthcare assistants, and household staff. A review of the rosters identified a shift leader and fire coordinator. An infection control lead was also allocated, and they were responsible for ensuring the provider's systems and policies regarding infection control were implemented in the centre during their shift.

The person in charge maintained planned and actual staff rosters. The inspectors reviewed the planned and actual rosters for April, May, and June 2024 and found that regular staff worked in the centre during these months, ensuring continuity of care for residents. In addition, all rosters reviewed accurately reflected the staffing arrangements in the centre, including the full names of staff on duty during both day and night shifts. There was a small number of vacancies in the centre that were under recruitment. In order to ensure consistency of care, two to three regular on-call staff were available to ensure that residents had consistent care provided to them.

Judgment: Compliant

Regulation 16: Training and staff development

Effective systems were in place to record and regularly monitor staff training in the centre. Inspectors reviewed the staff training matrix and found that staff had completed a range of training courses to ensure they had the appropriate levels of knowledge and skills to best support residents. These included training in mandatory areas such as fire safety, safeguarding of vulnerable adults and manual handling.

In addition, training was provided in areas such as human rights, feeding, eating, drinking and swallowing (FEDS), skills teaching, wheelchair clamping, assisted decision making, dementia and risk assessment. The person in charge told the inspectors that a review of the organisation's training matrix was underway to move supplementary training into mandatory training to reflect changes in practice. For example, while training in human rights and restrictive practice was classified as supplementary training, it was required in each centre.

There is a structured schedule in place for staff performance development and

supervision. Additionally, support was available to assist key workers in gaining confidence for their roles and the required procedures.

Judgment: Compliant

Regulation 21: Records

A review of staff personnel files took place on a separate date prior to the inspection at a campus administration building. They were found to contain the majority of the information and documents specified in Schedule 2 of the regulations. For example, the provider had valid contracts in place for staff members, references and a vetting disclosure from the National Vetting Bureau. However, it was noted that correspondence, reports, records of disciplinary action and any other records in relation to a person's employment were not contained within these files and required addressing.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure which identified the lines of authority and accountability. The centre was managed by a person in charge who was familiar with the care and support needs of the residents. The person in charge facilitated the inspection and was very familiar with the systems and processes in place to ensure sufficient oversight of the service. While they were new to the post of the person in charge, they had worked in the centre for a number of years. The inspectors also met with the CNM3 and programme manager as part of the inspection process and demonstrated a good understanding of the service, organisational operations, and the residents' care needs.

There were quality assurance audits to ensure that the service provided met the residents' needs. These audits, including the six-monthly provider visits, were of good quality and included an action plan for the person in charge to address. The last six-month unannounced audit was completed in February 2024 by three quality and safety advisors on behalf of the provider over eight and a half hours.

In addition, an annual review of the designated centre was conducted in 2023, meeting regulatory requirements. The review was found to be of high quality and adequately addressed the care and support compliance with relevant national standards. The inspector noted that the review represented the residents' views, and family members were invited to contribute to the findings. Oversight arrangements also included the completion of internal audits, which were completed by both the person in charge and by designated staff members. The annual review

discussed updates on priorities identified for the centre in 2023, including rights restorations, increased community inclusion, and quality improvement strategies to be implemented.

All audits, reviews, and past inspections were inputted into and tracked through a quality enhancement plan (QEP). The QEP captured the regulations that were assessed, the evidence findings, the actions required to meet compliance, and the status of the action plan.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had established and implemented an effective complaint-handling process. For example, there was a complaints and compliments policy in place. In addition, the person in charge was provided with the appropriate skills and resources to deal with a complaint and had a full understanding of the complaints policy.

The inspector observed that the complaints procedure was accessible to residents and in a format that they could understand. There was one complaint recorded in 2023 and one for 2024.

Judgment: Compliant

Quality and safety

This centre aimed to ensure that residents enjoyed living in this centre and that they considered it their home. There were systems in place to ensure that residents were supported to have a comfortable and meaningful life, and to have their needs met. There was an effective personal planning system in place, and the residents and their families were involved in the person-centred planning process. Overall, the inspectors found that the centre presented a comfortable home for the residents, and efforts were ongoing to enhance the facilities and services available to residents. Further fire containment improvements were required following a walkabout of the centre. The process for the annual assessment of the needs of each resident required review to ensure it contained all relevant information as set out in the regulations.

The provider had systems in place in relation to the identification, assessment and management of risk. There was a system in place for reporting adverse events including a system for emergencies. There was a local risk register in place which was regularly updated and there was evidence of shared learning at monthly staff

meetings. There were a number of restrictive practices implemented in the centre, including locked doors and gates. The person in charge told the inspectors about the rationale for the restrictions and the arrangements for their review. While it was seen that the centre had fire safety systems in place including a fire alarm, fire extinguishers and fire containment measures, as highlighted earlier in this report, it was observed by inspectors that one fire doors had a broken hold-open device and two doors were missing hold-open devices.

The inspectors viewed safeguarding plans and observed that the provider was evaluating the environment to balance the need for restrictive practices, maintaining residents' safety and affording them space to spend time away from other residents if they wished. It was self-identified that one house in the centre had a larger number of restrictive practices impacting other residents for the safety of one resident.

Due to the centre's large size, layout, and the number of residents living there, ensuring the centre could meet the needs of all residents was an area of concern for the provider, particularly for one resident who needed a lower stimulus environment. This requirement was under review by the person in charge with the development of new living spaces in the centre. The inspectors reviewed the arrangements for the assessment of needs. These assessments reflected the relevant multidisciplinary team input and informed the development of care plans that outlined the associated supports and interventions residents required. As previously mentioned, some expansion was required to ensure that the residents' personal and social needs were also included in the assessment process.

The residents' bedrooms were spacious, well laid out and included ample storage to keep their personal belongings. The rooms were personalised with some of the residents' personal items, like family photos and football memorabilia of the residents' favourite football teams. Each bedroom had a television if the resident wished, and some of the residents liked to spend some time in their personal sitting rooms watching their favourite programmes or football matches.

Good practices were in place in relation to safeguarding. Any incidents or allegations of a safeguarding concern were investigated in line with national policy and best practice. The inspectors found that appropriate procedures were in place, which included safeguarding training for all staff, the development of personal and intimate care plans, and support from a designated safeguarding officer within the organisation. Following a review of three residents' care plans, the inspectors observed that safeguarding measures were in place to ensure that staff who provided personal, intimate care to residents who required such assistance were in line with residents' personal plans and in a dignified manner.

Staff supported residents in maintaining their best health through ongoing monitoring and regular appointments with allied health care professionals such as dentists, psychologists, and psychiatrists when required. There were arrangements in place to provide positive behaviour support to residents with an assessed need in this area. Positive behaviour support plans in place were detailed, comprehensive and developed by an appropriately qualified person. The person in charge and staff

team were reviewing each residents positive behaviour support in line with identified changing needs in a timely manner. The provider had ensured that staff had received training in the management of behaviours of concern and received regular refresher training in line with best practice.

Residents' rights were another area that had been assessed through the provider's monitoring systems. The inspectors found that recommendations made through these reviews had been implemented. For example, residents were supported in purchasing their own towels instead of having them supplied by an external linen company. Human rights referral paperwork had also been submitted to the provider's human rights committee for oversight of restrictive practices. The historical practice of hourly night-time checks had changed since the last inspection. Where these occurred, there was a clear rationale or specific assessed need to indicate the use of them, ensuring residents' privacy and dignity were upheld at all times. The inspectors found that, overall, residents did not require such night-time checks.

Regulation 10: Communication

Residents in the centre presented with a variety of communication support needs. Communication access was facilitated for residents in this centre in a number of ways in accordance with their needs and wishes.

Alternative communication aids, including communication applications on tablet devices and televisions, were also being trialled with the residents. The provider's speech and language therapist was actively involved in this trial, which was in progress at the time of this inspection. The purpose of such aids were to assist residents in making greater choices in areas such as activities and meal choices.

The inspectors reviewed evidence of the different communication systems and aids that had been trialled with residents to further promote their communication needs. For example, the person in charge demonstrated the use of an application used by a number of residents in the centre. This application was used to assist resident to make a number of choices from meals plans and visual supports for activities of choice. The person in charge discussed that funding had been approved so that larger screens could be purchased for communal areas within the house to further enhance residents communication and promote greater independence in choice making.

The use of talking buttons was noted throughout the centre to support residents in informing staff they wanted to leave the centre, go on a bus drive, or have second portions of food.

Staff were in receipt of communication training which supported and informed their communication practice and interactions with residents living in this centre and as observed by the inspectors during the course of the inspection. The person in charge informed the inspectors that staff had received practice development in

LÁMH (a form of modified sign language). LÁMH champions were identified in each house, and LÁMH signs were introduced, signed and refreshed during the daily handover meeting.

Judgment: Compliant

Regulation 11: Visits

Residents were facilitated to receive visitors in-line with their expressed wishes in their home or arrange to meet in community locations. An alternative visiting arrangement was in place for one resident, which suited the needs of the resident and of their family members.

Judgment: Compliant

Regulation 17: Premises

The centre was a large single-storey building divided into four houses. It contained many rooms, including music rooms, television rooms, linen rooms, offices, stores, sensory rooms, kitchens, and dining rooms. The facilities available to residents were under review to ensure the best use of the large building and the number of unused rooms. Each room had an identified plan of action to bring it into functional use. All other areas in the centre that were currently operational, including residents' bedrooms and communal areas, were well maintained.

Residents had their own bedrooms, which were decorated to their individual style and preferences, and recognised their individuality. For example, their bedrooms included family photographs, pictures, soft furnishings and memorabilia.

During the walkabout with the person in charge, it was evident regular cleaning was taking place with dedicated house keeping staff rostered each day to uphold the cleaning standards in the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

A comprehensive risk register was maintained for the designated centre. The risk register accurately reflected the risks in the designated centre and was updated and reviewed regularly by the person in charge.

The person in charge regularly reviewed risks presenting in the centre and in doing so effectively identified and highlighted those risks and ensured control and mitigation arrangements were in place to manage the risks. There was good oversight of risk and incidents in the centre for identification of triggers and actions to reduce recurrence. The provider identified that an increase in some adverse events in 2023 resulted from positive risk-taking and a reduction in restrictive practices.

The inspectors also observed that staff were suitably informed of the risks presented within the centre and the control measures in place to manage them. The inspectors observed that risk management and shared learning from incidents and accidents were topics of discussion at staff meetings.

Risk assessments were individualised and included a falls risk management plan, manual handling assessment, and emergency evacuation plans. Control measures to mitigate against these risks were proportionate to the level of risk presented. Inspectors found evidence that restrictive practices in the centre were regularly reviewed with a view to reduce where possible and evidence as to why reduction plans were not successful

Judgment: Compliant

Regulation 28: Fire precautions

The provider had ensured fire safety management systems were in place. Fire safety equipment was subject to regular checks by an external company, including quarterly inspections and annual certification of the fire alarm and emergency lighting systems. However, during a walk through of the centre the inspectors found that two fire doors leading from the dining area to the kitchen were wedged open with base wedge holders to allow staff and residents easier access the kitchen during meal preparation. The wedges were immediately removed during the course of the inspection and the person in charged noted that fire door opening devices were part of the overall development plan for the centre. The inspectors also identified that a double fire door leading from the main corridor to one compartment of the designated centre had evidence of peeling and breakdown. The inspectors acknowledge that the provider had identified outstanding fireworks for the centre, however, on the day of the inspection no date had been set for the completion.

All residents had personal emergency evacuation plans (PEEPs) in place, which were subject to regular and recent review. These plans detailed the supports required by each resident to evacuate the building, in particular if a resident required prompting and additional support. The inspectors noted that regular fire drills were being carried out which included the least amount of staffing and the highest number of residents to evacuate the centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The provider and person in charge had ensured that all residents' personal plans included their goals, in addition to their likes and dislikes. All resident's plans were reviewed on an annual basis, and areas that were important to them formed the central part of these reviews. Five residents' files were reviewed. All residents had an annual health assessment that captured various elements of their required health supports. Other assessments were completed, including the resident's environment and a home and community assessment. The tool for capturing residents' health, personal, and social needs required review to ensure it adequately identified the needs of residents as prescribed by the regulations. Further exploration work was also required to ensure that the centre met residents' needs for a lower-stimulus living environment.

Residents' favourite activities were included in their weekly plans, such as going into the local community and visiting cafes, beaches, and scenic locations. Residents were also supported to enjoy sporting events, beauty treatments, and walks frequently. Residents were supported with skills teaching programmes related to social and daily living skills such as safety while crossing the road, empowering autonomy, baking, cooking and laundry. Residents also had the opportunity to learn horticulture skills in the centre's polytunnel and herb garden.

Judgment: Substantially compliant

Regulation 6: Health care

There was an assessment of need carried out for all residents on at least an annual basis, and this assessment identified the ongoing and emerging health care needs of residents. Individual health plans, health promotion and dietary assessments and plans were in place.

Residents in this centre had access to a variety of health-care professionals in order to meet their assessed needs. Residents accessed clinical appointments both through the provider's multi-disciplinary team and in the community, in accordance with their assessed needs.

The inspectors was told that residents were supported to access public health screenings when they were invited to attend these. The inspectors observed evidence where staff had presented education and guidance to residents in relation to screening process in a accessible format in order to assist residents to attend appointments.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspectors found that there were arrangements in place to provide positive behaviour support to residents with an assessed need in this area. For example, three positive behaviour support plans reviewed by the inspectors were detailed, comprehensive and developed by an appropriately qualified person. In addition, each plan included proactive, skills teaching and preventive strategies in order to reduce the risk of behaviours of concern from occurring.

The provider ensured that staff had received training in the management of behaviours of concern and received regular refresher training in line with best practice. Staff spoken with were knowledgeable of support plans in place and the inspector observed positive communications and interactions throughout the inspection between residents and staff. The inspectors found that staff had also received a bespoke training from the provider's psychology department which focused on each individual resident with an identified support plan and possible origins behind types of behaviours presenting.

There were a number of restrictive practices in use in the centre, and these had been assessed and reviewed by the provider when implemented. The person in charge was aware that a number of restrictions relating to one house, including a locked kitchen and movement sensors, were reflective of the assessed needs and challenges experienced by the large number of residents while living together in this designated centre.

Residents were supported in understanding restrictions through the use of social stories. These are short, simple stories that break down a situation, skill, event or behaviour into smaller steps using images and text to support the resident's understanding.

Judgment: Compliant

Regulation 8: Protection

The provider and person in charge had implemented systems to safeguard residents from abuse. For example, the provider implemented a policy in April 2024 with supporting procedures that clearly directed staff on what to do in the event of a safeguarding concern. In addition, all staff had completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns.

At the time of this inspection there were some open safeguarding concerns. However, the inspectors found that these had been reported and responded to as

required and formal safeguarding plans were in place to manage these concerns. The inspectors reviewed a sample of preliminary screening forms and found that any incident, allegation or suspicion of abuse was appropriately investigated in line with national policy and best practice.
Judgment: 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	Not compliant
Registration Regulation 7: Changes to information supplied for registration purposes	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for DC4 OSV-0002936

Inspection ID: MON-0034772

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**
Registration Regulation 5: Application for registration or renewal of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: Co-Ordinator and Programme Manager met on the 18.7.24 to discuss review of Statement of purpose. This is under review across all of Kildare Residential and will include the recommendations as outlined above. To be completed by 17.9.24	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Documents required under schedule 2, part k, are now on file for review.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The registered provider has identified the fire related non compliances noted on the day of the inspection and a business case has been issued to the Service Funder for works to be completed. Awaiting approval of same. To be completed by the 29.11.24	
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: The Co-Ordinator and Programme Manager have met to discuss the assessment of need. Co-Ordinator gathered information from external services and databases with a view to	

developing a service specific assessment of need.
The programme manager presented a draft assessment of need to the quality and safety team on the 15.7.24 for feedback. Development is ongoing.

Completed by 17.9.24.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Registration Regulation 5(1)	A person seeking to register a designated centre, including a person carrying on the business of a designated centre in accordance with section 69 of the Act, shall make an application for its registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 1.	Not Compliant	Orange	17/09/2024
Regulation 21(1)(a)	The registered provider shall ensure that records of the information and documents in relation to staff specified in Schedule 2 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	31/07/2024

Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	29/11/2024
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	17/09/2024
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).	Substantially Compliant	Yellow	17/09/2024