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:	Liffey 2
Name of provider:	St John of God Community Services CLG
Address of centre:	Dublin 24
Type of inspection:	Announced
Date of inspection:	27 August 2024
Centre ID:	OSV-0002977
Fieldwork ID:	MON-0036348

About the designated centre

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

Liffey 2 provides respite to adults for up to seven adults with an intellectual disability. It is made up of one centre in a large town in Co. Dublin. The residents are supported 24/7 by a staff team that is comprised of nursing staff, social care workers and healthcare assistants. There are community based facilities and services available for the residents which include Speech and language therapy, occupational therapy, physiotherapy, psychology, and psychiatry. All residents availing of the respite service also attend the day services in the organisation.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Tuesday 27 August 2024	09:55hrs to 16:50hrs	Kieran McCullagh	Lead
Tuesday 27 August 2024	09:55hrs to 16:50hrs	Jennifer Deasy	Support

What residents told us and what inspectors observed

This was an announced inspection, completed to monitor the provider's compliance with the regulations and to inform decision making in relation to renewing the registration of the designated centre.

The inspection was facilitated by the person in charge for the duration of the inspection. Inspectors used conversations with residents and staff and observations of care and support, in addition to a review of documentation, to form judgments on the quality and safety of care.

This inspection found that residents were in receipt of good quality care and support in line with their assessed needs. There were defined management systems however there were some gaps in the local oversight arrangements which were impacting on the governance of the centre. Additionally, there were serious risks identified in respect of the fire safety management systems. For this reason, on the day of the inspection, inspectors took the unusual action of issuing the provider with an urgent action in relation to Regulation 28: Fire precautions due to observed risks with the fire evacuation procedures.

Following the inspection, the provider submitted an urgent compliance plan in relation to risks identified by inspectors. The provider set out actions they would take in order to bring the centre back into compliance. The compliance plan was reviewed by inspectors, which gave assurances that the provider would take necessary actions to mitigate against risks identified. This is discussed further under Regulation 28: Fire precautions.

The centre provided residential respite services for approximately 40 individuals at the time of inspection. A maximum of seven residents could be accommodated at any one time. On the day of inspection there were five residents availing of the service. The service had the capacity to operate seven days a week and those who availed of respite services here normally received day service supports from St. John of Gods.

Inspectors found that the centre was reflective of the aims and objectives as set out in the centre's statement of purpose. The statement of purpose detailed that the service intended to "be a person-centred service, nurturing, promoting, and enhancing the dignity, growth, and wellbeing of each individual". Inspectors found that this was a service that ensured that residents received the care and support they required and in a meaningful and person-centred manner.

The designated centre comprised of one respite centre located on the ground floor of a three-storey block in a large urban area of South Dublin. The centre was comprised of seven single occupancy bedrooms, a staff office, a multisensory room, a lounge, a dining room, a kitchen, a utility room, a bathroom and a large shower room. The centre was close to many amenities and services including a large

shopping mall, cafes, restaurants, and public transport.

On arrival to the centre, inspectors were greeted by the person in charge who took the inspectors' identification to verify the purpose of their visit. All residents were at their day services so inspectors used this time to view the building, review documentation and discuss the service with staff members on duty.

The physical environment of the centre was found to be clean, tidy and well-maintained. The design and layout of the centre ensured that residents could enjoy staying in an accessible and comfortable environment during their respite break. In general, inspectors found the atmosphere of the centre presented as welcoming and as an inviting sense of familiarity for residents.

The dining room was the hub of the centre and all residents were observed to gather there at different times and moved around the centre with ease between the various communal areas and the privacy of their bedrooms. The dining room had been decorated to reflect an American-style diner and had a juke box, menu and coffee dock for residents to enjoy. An interactive projector was set up on the dining room table for residents to engage in games and activities. One wall of the diner displayed many photographs of residents engaging in community and in-house activities including; going to the cinema, baking, pumpkin carving and eating out. A staff office had recently been converted into a multisensory room and was furnished with beanbags, a bubble column and fibre optic lights. This was a calming space which inspectors was told was enjoyed by many of the residents.

The centre was very clean and inspectors saw that there were housekeeping staff available to the centre who maintained the cleanliness of the premises. The inspectors spoke to two of the household staff and found that they were informed of their delegated roles and responsibilities and of the local operating procedures to ensure the centre was maintained in a clean and hygienic manner. Household staff were seen to use appropriate cleaning equipment and materials. For example, colour coded mops and cloths were used for different household areas. Inspectors saw that there were ample hand hygiene facilities throughout the centre with wall-mounted hand sanitiser in key locations and sinks with soap and paper towels.

One bathroom, while generally in a good state of repair, required works to ensure that it was accessible to all residents as the bath was not accessible to those with mobility issues. The inspectors were told that the provider had plans to complete these works in the coming months. In the interim, residents had access to an accessible bath in the centre's wetroom. There was equipment available to support accessibility. For example, ceiling tracking hoists were installed in the wetroom along with an accessible bath.

The kitchen was seen to be very clean and well-maintained. Inspectors saw that there were appropriate procedures in place to ensure that residents' individual dietary needs were met during their stay. For example, there were two toasters available, one of which was designated as the toaster for gluten-free bread. Gluten-free foods as required by residents' needs were kept separate to other foods to ensure they were not contaminated.

While the centre was generally well-maintained, inspectors identified potential risks with the main fire evacuation corridor. One fire door leading from the utility to this corridor was damaged and would not have been effective in containing smoke or fire. Additionally, an electrical cupboard located in the corridor did not have a suitable ceiling to prevent fire from spreading through the ceiling space from this cupboard to the corridor. Inspectors observed that this was not fitted with a fire detection device. This risk was identified to the person in charge and service manager and an urgent action was issued. This will be discussed further under Regulation 28.

Inspectors met with three residents on their arrival back from their day service. Two of the residents spoke to the inspectors in more detail about their experiences of staying in the centre. One resident told inspectors that they were happy staying there and that they were supported to stay in touch with family during their visit. This resident had brought some of their favourite belongings from home, including their games console and showed one of the inspectors how this was set up in their bedroom on the wall-mounted television.

Another resident told one of the inspectors about their family and their interests. They said that staff in this centre were helpful. The inspector saw this resident having a drink using an adapted cup, which was detailed as a recommendation in one of their care plans. The inspectors saw gentle interactions between residents and staff. For example, staff carefully prompted residents who used wheelchairs to lift their hands when assisting them to sit at the table so their arms did not get caught**.**

Weekly ''Speak Up Meetings'' were held. Inspectors reviewed minutes from the most recent meeting and agenda items included; comments and feedback, new issues and concerns, outings, events and activities, meal planning and complaints and advocacy, making it clear that the staff and management team valued the opinions of the residents.

In advance of the inspection, residents had been sent Health Information and Quality Authority (HIQA) surveys. These surveys sought information and residents' feedback about what it was like to live in this designated centre and were presented to inspectors on the day of the inspection. The feedback in general was very positive, and indicated satisfaction with the service provided to them in the centre, including; the staff, activities, people they live with, food and the premises. Residents' comments included; ''am happy'', ''I like the fried rice that staff make'' and ''familiar staff help me to feel less anxious and more relaxed''.

Staff spoke with inspectors regarding residents' assessed needs and described training that they had received to be able to support such needs, including safeguarding, medication management, managing behaviour that is challenging and feeding, drinking, eating and swallowing (FEDS). In addition, some staff had completed training in human rights and inspectors observed this in practice on the day of the inspection. For example, one staff member spoken with told inspectors about using the FREDA principles in everyday practice and respecting residents'

rights to privacy and dignity.

It was evident that the staff team were familiar with the needs of the different residents. For example, staff members were familiar with each person's dietary preferences and preferred pastimes. Residents were observed to be at ease among the staff members and enjoyed their company.

The views of the residents' families were very positive, and were detailed across multiple documents reviewed during the inspection. The provider frequently sought the views of residents and their families as part of the service's ongoing commitment to quality improvement. For example, discharge calls following every respite stay were made and compliments and feedback was recorded in a compliments log maintained by the person in charge. From what inspectors were told and observed during the inspection, it was clear that residents looked forward to their respite breaks, received a good quality of service, and were being supported through a person-centred approach.

The next two sections of the report 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 delivered to each resident living in the centre.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

Overall, this inspection found that, while there were defined management systems in place, an unplanned absence of a local senior manager along with the large remit of the person in charge was impacting on the local oversight arrangements. This was resulting in some gaps in the oversight and control of risks including fire-related risks.

There was a regular core staff team in place. They were very knowledgeable of the needs of the residents and had a very good rapport with them. The staffing levels in place in the centre were suitable to meet the assessed needs and number of residents that attended. Due to an existing vacancy the provider was ensuring continuity of care and support through the use of regular relief and agency staff. Inspectors met with staff members during the inspection and found they were knowledgeable in relation to the needs of residents and were clear on the key policies and procedures within the centre.

The staff team were in receipt of regular support and supervision. They also had access to regular refresher training and there was a high level of compliance with mandatory training. Staff had received additional training in order to meet resident's

assessed needs. For example, staff had received training in communication and dysphagia.

The provider had implemented clearly defined management structures. The staff team reported to a social care leader who, inspectors were told ordinarily provided oversight of the day-to-day running of the centre. They, in turn, reported to a person in charge. The person in charge was supported in their role by a programme manager. However, the social care leader for this centre had been on unplanned leave for a period of time. This was found to be impacting on the day-to-day governance of the centre. For example, there were risks in respect of fire evacuation which had not been escalated to the person in charge, and therefore were not controlled for adequately through risk assessments.

The provider had in place a series of audits at both local and provider level to ensure oversight of the quality and safety of care. While these audits were comprehensive and were used to inform a Quality Enhancement Plan (QEP), inspectors found that the time frame for actions to be taken to address risks required review. In some instances, the time frame was not considered timely enough to control for a potentially high risk to the safety of residents, in particular in respect of fire containment and evacuation.

The registered provider had prepared a written statement of purpose that contained the information set out in Schedule 1. The statement of purpose clearly described what the service does, who the service is for and information about how and where the service is delivered.The provider ensured that the building and all contents, including residents' property, were appropriately insured. The insurance in place also covered against risks in the centre, including injury to residents.

There was an effective complaints procedure in place which was accessible and in a format that residents could understand. Residents were supported through the complaints process, which included having access to an advocate when making a complaint or raising a concern. Inspectors found that there was a culture of openness and transparency that welcomed feedback, the raising of concerns and the making of suggestions and complaints.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted an application seeking to renew the registration of the designated centre to the Chief Inspector of Social Services. The provider had ensured information and documentation on matters set out in Schedule 2 and Schedule 3 were included in the application.

In addition, the provider had ensured that the fee to accompany the renewal of

registration of the designated centre under section 48 of the Health Act was paid.

Judgment: Compliant

Registration Regulation 8 (1)

Since the previous inspection the registered provider had submitted an application to the Chief Inspector of Social Services under section 52 of the Health Act for the variation of conditions of registration.

The provider had submitted all information in line with the regulations including; the conditions to which the application referred and reasons for the proposed variation. In this instance, the provider applied for variation of conditions one and three of the designated centre, which was granted.

Judgment: Compliant

Regulation 15: Staffing

On the day of the inspection the provider had ensured that there were 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 each premises.

There was one whole time equivalent staff vacancy at the time of inspection and recruitment was underway to back fill this position. The person in charge maintained a planned and actual staff roster. Inspectors reviewed planned and actual rosters for the months of May, June, July and August and found that regular staff were employed, including regular relief and agency staff, meaning continuity of care was maintained 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.

Inspectors spoke to three staff members, and found that they were knowledgeable about the support needs of residents and about their responsibilities in the care and support of residents.

Inspectors reviewed three staff records and found that they contained all the required information in line with Schedule 2, including evidence of professional references and vetting by An Garda Síochána.

Judgment: Compliant

Regulation 16: Training and staff development

There was a very high level of compliance with mandatory and refresher training maintained in the centre. Inspectors reviewed the training records for all staff and saw that all staff were up-to-date in training in key areas including safeguarding, hand hygiene and managing behaviour that is challenging.

Additionally, staff were up-to-date in trainings required by residents' specific needs. For example, all staff had received training in dysphagia and in communication. Inspectors asked staff about some of the resident's associated care plans in these areas and found that staff were well informed of the measures to ensure that residents were supported to communicate and to eat, drink and swallow safely and effectively.

Staff were in receipt of regular support and supervision through monthly staff meetings and individual staff supervisions which took place three times per year. Inspectors reviewed the records from the most recent individual supervision sessions for three staff. These were found to cover key areas relating to staff member's roles and responsibilities including, for example, staff training, residents' needs and infection prevention and control. Action plans were developed during supervision meetings for any performance related issues.

One inspector reviewed the records of two recent staff meetings and saw that these were used to discuss relevant areas including; safeguarding, residents' rights and restrictive practices. Some staff had completed human rights training and inspectors saw that FREDA principles were discussed at recent staff meetings.

Judgment: Compliant

Regulation 22: Insurance

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.

Inspectors reviewed the insurance 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

There were clearly defined management systems in the centre. The staff team reported to a social care lead who in turn reported to a person in charge. The person in charge was supported by the service manager. However, an unplanned absence of the social care leader for a period of time had resulted in some gaps in the oversight of risks. For example, the non-compliance of two residents with fire evacuations should have been escalated to the person in charge's attention through the incident management system however this had not occurred.

The person in charge had additional responsibilities as a senior manager for two other centres and could not be present in the designated centre on a daily basis to oversee the safety of care. While the person in charge had implemented systems to assist them in overseeing the centre, for example, other senior managers had stepped in to complete staff supervisions, the inspection found that the absence of a social care leader had resulted in some risks to the safety of residents which were not adequately controlled for.

There were systems in place to ensure that all staff, including the person in charge, were in receipt of regular support and had opportunities to raise concerns regarding the quality and safety of care. Staff had regular supervision meetings, as discussed under Regulation 16. The person in charge attended monthly meetings with the programme manager and discussed incidents and service needs at these meetings.

The provider had in place a series of comprehensive audits both at local and provider level. For example, at local level, regular hand hygiene, medication management and environmental audits were completed. Action plans were implemented where risks were identified on these audits.

The provider had also completed regular six monthly audits of the quality and safety of care. These audits had identified many of the risks found on the current inspection. For example, the audit in February 2024 found that a fire door posed a risk to containment of smoke and fire. The next six monthly audit in August identified a fire risk in respect of the ceiling tiles on the corridor. These were used to inform a quality enhancement plan which detailed actions to be taken to address risks to the quality and safety of care.

However, inspectors found that the time frame for actions to address risks required review to ensure that serious risks to the safety of care were responded to in a timely manner. For example, the defective fire door identified as a risk on the audit in February had not been addressed by the time of the inspection. Additionally, the time frame for review of the ceiling tiles on the main evacuation corridor by the provider's maintenance team was set out as February 2025. Both the defective fire door and the ceiling tiles were located on the main evacuation corridor and potentially posed a serious risk to the safe evacuation of residents in the event of a fire. Therefore a more timely action plan to address the risk was required.

Judgment: Substantially 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.

Inspectors 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. The statement of purpose was available to residents and their representatives in a format appropriate to their communication needs and preferences.

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

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had established and implemented effective complaint handling processes. For example, there was a complaints policy in place. In addition, staff were provided with the appropriate skills and resources to deal with a complaint and had a full understanding of the complaints policy.

Inspectors observed that the complaints procedure in place was accessible and in a format that the residents could understand. Residents were supported through the complaints process, which included having access to an advocate when making a complaint or raising a concern.

On the day of the inspection there was one open complaint. Inspectors reviewed the complaints log, which was maintained by the person in charge and found that complaints were followed up, resolved and managed in a timely manner, as per the provider policy.

Inspectors found there was a culture of openness and transparency that welcomed feedback, the raising of concerns and the making of suggestions and complaints. For example, residents participated in "Speak Up Meetings" in which they had the opportunity to raise any issues or concerns during their respite stay. In addition, feedback was sought from residents" families and representatives through discharge telephone calls at the end of every respite stay.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of the service for the residents who lived in the designated centre. Overall, inspectors found that residents were supported to avail of a respite break in a comfortable and clean premises and that care was provided in a manner which met their assessed needs and considered their individual preferences and choices. However, the fire management systems required review to ensure the safety of residents in the event of an emergency.

Inspectors completed a walk around of the centre with the person in charge. The designated centre was found to be bright and spacious and in a good state of repair. There were seven single occupancy bedrooms for residents availing of the service, allowing them their own private space during their stay. There was also a communal kitchen/dining area and most areas of the centre were accessible to residents and suitable for their assessed needs. Suitable arrangements were observed for the safe storage of residents' personal belongings during their stay. There were adequate arrangements in place for residents to launder their clothes during their stay in respite.

Residents had access to food and nutrition in line with their assessed needs and dietary preferences. There were systems in place to ensure that residents had choice in respect of their mealtimes. Staff had received training in dysphagia and there were a sufficient number of suitably skilled staff to support residents during their meals.

There were a number of fire safety risks identified on this inspection. In particular, there were risks to the effective containment of smoke and fire from the main emergency exit corridor and there was a risk to two residents as the provider had not demonstrated they could safely evacuate them in the event of an emergency. The fire management systems required review to ensure a timely response to fire containment risks and to ensure there were detailed risk assessments and control measures to ensure that all residents could be safely evacuated.

The person in charge ensured that there were appropriate and suitable practices relating to medicine management within the designated centre. This included the safe storage and administration of medicines, medicine audits, medicine sign out sheets and ongoing oversight by the person in charge.

Inspectors reviewed a sample of residents' files and saw that residents had up-to-date and comprehensive individual assessments and care plans. These had been informed by the resident, their family and multi-disciplinary professionals. Staff spoken with were knowledgeable fo these care plans.

Where required, positive behaviour support plans were developed for residents, and staff were required to complete training to support them in helping residents to manage their behaviour that challenges. The provider and person in charge ensured

that the service continually promoted residents' rights to independence and a restraint-free environment. For example, restrictive practices in use were clearly documented and were subject to review by appropriate professionals.

Good practices were in place in relation to safeguarding. Any incidents or allegations of a safeguarding nature were investigated in line with national policy and best practice. Inspectors found that appropriate procedures were in place, which included safeguarding training for all staff, the development of personal and intimate care plans to guide staff and the support of a designated safeguarding officer within the organisation.

Regulation 17: Premises

Inspectors carried out a walk around of the centre in the presence of the person in charge, which confirmed that the premises was laid out to meet the assessed needs of the residents.

Efforts had been made by the provider to make the centre homely in nature and inspectors observed that it was tastefully decorated. For example, artwork, mirrors and photographs of residents who used the service were displayed throughout the centre. Inspectors observed a sensory wall panel in the dining room, which provided opportunities for residents to be creative and problem-solve along with an interactive sensory table. In addition, the person in charge informed inspectors that funding had been secured through the provider's funder for the renovation of the bathroom to ensure that both bathrooms were fully accessible to all residents.

Each resident had their own bedroom for the duration of their stay. Residents could store their belongings in individual wardrobes, drawers and lockers in their bedrooms, and laundry services were available for those who needed them. In addition, each bedroom had it's own television and residents were observed watching their favourite television programme during the course of the inspection. The centre was warm and clean throughout and well-maintained to provide a comfortable living environment.

Overall, the centre was found to be clean, bright, nicely furnished, comfortable, and appropriate to the needs and number of residents using the designated centre. Residents indicated to inspectors that they were happy with the centre.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents in this centre were provided with food and drink which was consistent with their dietary preferences and needs. Some residents had assessed feeding,

eating, drinking and swallowing (FEDS) needs and the inspectors saw that there were up-to-date care plans on file which detailed their support needs in these areas. Inspectors spoke with two staff members regarding residents' FEDS care plans and found that staff were well-informed of these and that staff had received specific training in respect of these needs.

Staff told the inspectors that they had access to equipment required to modify foods in line with residents' care plans. The inspectors also saw that there were procedures to ensure that residents' with food allergies or sensitivities had food which was kept separate from other foods to avoid cross contamination.

Inspectors saw residents have drinks and snacks on their return from day service. Residents had access to specialist eating and drinking equipment in line with their assessed needs.

Inspectors were told that speak up meetings took place on admission with residents and that these were used as an opportunity to plan the menu and snacks for the respite stay. Residents were supported to choose their preferred meals and snacks and these were purchased by the provider and were made available to residents during their stay.

Judgment: Compliant

Regulation 28: Fire precautions

There were a number of fire safety risks identified on this inspection which posed a risk to the safety of the residents. Due to these risks, an urgent action was issued to the provider which required them to submit an urgent compliance plan detailing the response they would take to address these risks in a timely manner.

Some of the risks were known to the provider, however inspectors found that these had not been addressed in a timely manner. For example, the provider's six monthly audit form February 2024 identified that two fire doors had been altered and vents had been installed. These potentially rendered the doors defective and insufficient to contain smoke and fire. One of these fire doors was installed at the entrance to the utility room which was a high risk area, and the fire door opened directly onto the main evacuation route from residents' bedrooms to the emergency exit at the front door. The insufficient containment measures posed a serious risk to the safety of residents in the event of fire. However, the fire doors had not been replaced within the six months between the February audit and the date of the inspection.

Inspectors also found that an electrical cupboard which was located in the main evacuation corridor posed an additional risk to the safe evacuation of residents. While the cupboard was fitted with fire doors, there was no ceiling installed to contain smoke or fire. The ceiling of the cupboard appeared to open and connect directly with the ceiling of the main evacuation corridor and this ceiling was comprised of tiles which would not have been effective to contain smoke or fire. The

provider had identified on the most recent six monthly audit that the ceiling tiles may pose a risk to the evacuation arrangements. However, the time frame to review this risk was set as February 2025 and did not demonstrate a timely response to a high risk. The provider's audits had not identified the additional risk posed by the poor fire and smoke containment in the electrical cupboard. Additionally, there was no smoke detector installed in the electrical cupboard.

The provider had not ensured that all residents could be evacuated in the event of an emergency. Two residents were detailed as regularly refusing to comply with fire drills. Inspectors reviewed these residents' personal evacuation plans and found that they were insufficiently detailed to guide staff on the procedure to evacuate residents in the event of non-compliance during an emergency. Staff spoken with were unclear on the response to be taken in the event of residents refusing to evacuate. A risk assessment was in place for one of these residents. However, this risk assessment was insufficiently detailed and did not contain adequate control measures for the risk. There was no risk assessment available in respect of the second resident who had refused to evacuate fully on two recent fire drills.

While inspectors were told that there were local operating procedures to assist in managing these risks there was insufficient documentation to verify that these procedures were being implemented. For example, inspectors saw on a risk assessment that staff were to contact the local fire service to inform them of when residents were staying in respite who were non-compliant with evacuations. However, there was no log maintained of this contact being completed. The person in charge also stated that the non-compliance of residents with fire drills should have been escalated through the management systems by completing incident logs however this had not occurred.

Following the inspection the provider submitted an urgent compliance plan, which outlined the actions they would take. The inspectors reviewed the response and were assured that provider would put in place necessary actions to bring the centre into compliance. For example, the provider outlined the following in their plan:

- As an immediate mitigation, a battery smoke detector was placed in the electrical fuse room on the 29 August 2024 by the provider's maintenance team
- As an immediate mitigation, risk assessments have been updated and shared with the team for those not evacuating and more detailed personal emergency evacuation plans were implemented to guide practice
- Fire Safety Consultant will conduct a review on 12 September 2024 to review fire containment in Liffey 2
- Two fire doors with vents to be replaced by the end of November 2024

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

There were safe practices in relation to the receipt and storage of medicines. The provider had appropriate lockable storage in place for medicinal products and a review of three resident's medicine administration records indicated that medicines were administered as prescribed.

Medicine administration records reviewed by inspectors clearly outlined all the required details including; known diagnosed allergies, dosage, doctors details and signature and method of administration. Staff spoken with on the day of inspection were knowledgeable on medicine management procedures, and on the reasons medicines were prescribed. Staff were competent in the administration of medicines and were in receipt of training and on-going education in relation to medicine management.

All medicine errors and incidents were recorded, reported and analysed and learning was fed back to the staff team to improve each resident's safety and to mitigate against the risk of recurrence.

In addition, inspectors observed there were regular medicine audits being completed in order to provide appropriate oversight over medicine management.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspectors reviewed the individual assessments and care plans for five residents. Inspectors found that each resident had an up-to-date and comprehensive assessment which was used to inform person-centred care plans. Residents' assessments were informed by relevant multidisciplinary team professionals, their family members and the resident themselves. Care plans were detailed and provided staff with information on meeting the assessed need in a manner which upheld residents' autonomy, dignity and privacy. Care plans were in place for each assessed need including, for example, dental care, skin care, intimate care and sleep management.

Judgment: Compliant

Regulation 7: Positive behavioural support

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 inspectors were detailed, comprehensive and developed by an appropriately qualified person. In addition,

each plan included antecedent and setting events, proactive and reactive strategies in order to reduce the risk of behaviours that challenge from occurring.

The provider had ensured that staff received training in the management of behaviour that is challenging and received regular refresher training in line with best practice. Staff spoken with were knowledgeable of support plans in place and inspectors observed positive communications and interactions during the inspection between residents and staff.

There were a number of restrictive practices used in the designated centre which had been been notified to the Chief Inspector of Social Services in line with regulations. Inspectors completed a review of these and found they were the least restrictive possible and used for the least duration possible.

In addition, inspectors found that provider and person in charge were promoting residents' rights to independence and a restraints free environment. For example, restrictive practices in place were subject to regular review by the provider's restrictive practice committee, appropriately risk assessed and clearly documented and appropriate multi-disciplinary professionals were involved in the assessment and development of the evidence-based interventions with residents.

Judgment: Compliant

Regulation 8: Protection

The registered provider and person in charge had implemented systems to safeguard residents from abuse. For example, there was a clear policy and standard operating procedure in place, which clearly directed staff on what to do in the event of a safeguarding concern.

All staff had completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns. Staff spoken with were knowledgeable about their safeguarding remit.

On the day of the inspection there were four safeguarding concerns open. Following a review of these, inspectors found that concerns had been responded to and appropriately managed. For example, interim safeguarding plans had been prepared with appropriate actions in place to mitigate safeguarding risks. In addition, inspectors reviewed three preliminary screening forms and found that incidents, allegations or suspicions of abuse were appropriately investigated in line with national policy and best practice.

Following a review of three residents' care plans inspectors observed that safeguarding measures were in place to ensure that staff provided personal intimate care to residents who required such assistance in line with residents' personal plans and in a dignified manner.

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	Compliant
Registration Regulation 8 (1)	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Liffey 2 OSV-0002977

Inspection ID: MON-0036348

Date of inspection: 27/08/2024

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • A new PIC has been appointed for the centre in a full-time capacity and will commence Oct 14th, 2024. • All actions from the providers 6 monthly unannounced inspections were on the Quality Enhancement plan for completion. • A fire officer attended the centre for a review Sept 11th and completed the following: Checked the void in the false ceiling above the electrical room as well as a section of this void in the bedroom corridor. The main ceiling is a steel corrugated base with concrete poured over it. There are compartment walls running up to this ceiling area in the areas inspected above the walls. This ensures that there will be no smoke travel between rooms in the false ceiling space.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Reg 28(1) • Our Fire Safety Consultant, MSA, conducted a review on 11th Sept 2024 to review fire containment in Liffey 2, with our Regional Health and Safety Officer in attendance for additional local input. The fire officer advised the following: Checked the void in the false ceiling above the electrical room as well as a section of this void in the bedroom corridor. The main ceiling is a steel corrugated base with concrete poured over it. There are compartment walls running up to this ceiling area in the areas inspected above the walls. This ensures that there will be no smoke travel between rooms in the false ceiling space • 2 x fire doors with vents are to be replaced. The doors have been ordered and lead in time for fire doors for the moment has been 6 to 8 weeks after order is confirmed. This would give 10 to 12 weeks as the timeframe between confirming quotes and install	

dates. Completion date:25/11/24

• As an immediate mitigation, a battery smoke detector was placed in the electrical fuse room on the 29th of Aug 2024 by our maintenance team. Our contractor for maintaining our fire detection systems, Seakel, attended the site on the evening of the 28th of August, and we will address any actions advised by them. New ceiling tiles were also put in place 29th August 2024 eliminating any gaps in the ceiling.

Reg 28(3)

• After each scheduled fire drill, the staff team will escalate non evacuations to the PIC as well as on the observation sheet for additional oversight. All Personal Emergency Evacuation Plans (PEEP) will be updated after each drill outlining measures to ensure safe evacuation. Fire safety will remain a standing item discussed at monthly staff team meetings including discussion regarding residents level of compliance during fire evacuation.

• Allocations will be reviewed to ensure adequate fire evacuation measures are in place for all attendees weekly by PIC and PM.

• Risk assessments have been updated and shared with the team for those not evacuating and more detailed PEEP's implemented to guide practice. Both residents recorded as non-compliant with evacuations will have a repeat fire drill during their next respite visit. Social stories have been implemented for those who need more support to evacuate safely.

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 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	14/10/2024
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and	Substantially Compliant	Yellow	27/09/2024

	support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Red	25/11/2024
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	25/11/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	25/11/2024
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Red	28/08/2024