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:	Tullycoora House
Name of provider:	Trinity Support and Care Services Limited
Address of centre:	Monaghan
Type of inspection:	Announced
Date of inspection:	09 July 2024
Centre ID:	OSV-0008059
Fieldwork ID:	MON-0036699

About the designated centre

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

Tullycoora House consists of a two storey large house with a wraparound garden and an additional apartment with a large back garden that can cater for one individual. The centre is in the countryside close to a nearby town. Facilities offered within Tullycoora House support residents to experience life in a home like environment and to engage in activities of daily living typical to those which take place in many homes, with additional supports in place in line with residents' assessed needs. Residents are support by a team of social care staff, team leaders and a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 9 July 2024	10:20hrs to 19:20hrs	Karena Butler	Lead

What residents told us and what inspectors observed

Overall, this inspection found that residents were happy and content in their home. However, some improvements were required in a number of areas. They related to healthcare, positive behaviour support, communication, staffing, premises, governance and management, fire precautions, medicines management and notification of incidents. These areas will be discussed in more detail later in the report.

The inspector had the opportunity to meet the three residents that were living in the centre.

The residents did not attend an external day program and instead were supported each day by the centre staff. One resident had applied for an external educational program and had also recently interviewed for a job. From speaking with that resident, it was evident that they were very hopeful that they would get the job and said that they liked doing that kind of work. When discussing how they felt about living in the centre, they said that they were happy, they felt safe and they chose their room and the paint colours. They said that they would be buying new bed linen soon. The resident said that, they could chose what they ate, the activities they participated in and that staff supporting them were really nice and they couldn't ask for any better.

Another resident spoke briefly with the inspector and said they were happy. After that they wanted to talk about discussion topics that were of interest to them.

Some residents, with alternative communication methods, did not share their views with the inspector, and were observed at different times during the course of the inspection in their home.

On the day of the inspection, residents' activities varied depending on their choices. Activities included going for a family visit, going to a shopping centre for lunch out and the third resident went for a visit to the library followed by completing food shopping for the house.

Over the course of this inspection, the inspector observed staff on duty and the assistant manager use relaxed and respectful communication when speaking with the residents. For example, the assistant manager asked a resident for their permission to enter their apartment and asked if it was okay if they sat with them.

Residents were observed to appear relaxed and comfortable in their home and in the presence of staff. For example, one resident was observed chatting easily and joking with a staff member. Another resident was observed smiling in the presence of their support staff and the third resident was observed having lunch with their support staff while listening to their favourite music on their electronic device.

The provider had arranged for staff to have training in human rights. One staff member spoken with said that they ensure they gave residents choice in their daily life. They said that they also ensured residents had the right to refuse and change their minds and to reassure them that it was okay to change your mind.

The inspector observed the house and apartment to be very tidy; however, a more thorough clean was required in some areas. Each resident had their own bedroom and there was adequate storage facilities for personal belongings. They were individually decorated to suit the preferences of each resident. For example, each was painted in colours of the resident's choice.

There were multiple communal spaces for residents to have space in the main house, for example there were two living rooms. The resident living in the separate apartment had a private living space just for them. There was a large garden accessible to the residents in the main house and a separate garden for the apartment. The gardens had a trampoline and a go kart available for use.

As part of this inspection process residents' views were sought through questionnaires provided by the Health Information and Quality Authority (HIQA). Responses came back by way of a representative on behalf of one resident and it was unknown who supported the second resident to respond. The third resident answered themselves with some support from a staff member. Feedback received was positive. One resident stated that they couldn't wish for a better place and said they never wanted to leave.

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

Capacity and capability

This inspection was announced and was undertaken following the provider's application to renew the registration of the centre. This centre was last inspected in January 2023. From a sample of the actions reviewed from the previous inspection, they demonstrated that the provider had actioned and completed the areas identified as requiring improvement.

While there were management systems in place to ensure that the service provided was safe, for example through the use of a number of auditing systems, improvements were required to ensure that the service provided was consistent and appropriate to meet the residents needs. In addition, improvement was required with the arrangements for completing the annual review to ensure it was as per the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations).

The inspector observed that there was a statement of purpose in place that was reviewed and updated on a regular basis as required.

The inspector reviewed a sample of rosters and they indicated that safe staffing levels were being maintained. However, improvements were required to ensure there were reliable staffing arrangements in place due to the fact that the centre did not have its full whole time equivalent (WTE) of staffing as outlined in their statement of purpose.

The provider had ensured staff had access to training and development opportunities in order to carry out their roles effectively. Staff were found to be in receipt of formal supervision which facilitated staff development.

For the most part, the provider had suitable arrangements for the submission of notifications as required. However, some required notifications were not submitted as required. However, they were submitted following the inspection.

Regulation 15: Staffing

A sample of rosters was reviewed over a three month period from May to July 2024. While they demonstrated to date that all of the required shifts were filled in order to provide safe staffing levels, it was clear from the rosters that the centre did not have its full WTE (Whole Time Equivalent) levels of staffing as per the statement of purpose. From speaking with the assistant manager and the assistant director, they communicated to the inspector that nine WTE positions were required. The assistant manager informed the inspector that one new resident was due to move to the centre in the coming weeks. Ensuring the centre had the required WTE of staffing was particularly important given that the registered provider wanted to increase the number of residents being supported in the centre.

The provider was actively recruiting to fill the vacant posts and seven new staff were in pre-employment checks, of which five were in pre-employment checks since March 2024. However, improvement was required to ensure that staffing arrangements in the centre were reliable as there was an over-reliance on relief and agency staff being utilised to fill the vacant positions. Additionally, there was an over-reliance on the goodwill of the fulltime staff to work in excess of their contracted hours in order to ensure shifts were covered. For example, from a review of two staff members' hours across a five week period, their hours averaged at 58.4 hours per week for the first staff and 51.6 hours per week for the second staff. It was clear the provider was trying to ensure that staff that worked in the centre, including the agency staff, were consistent in order to provide continuity of care for the residents. However, staff repeatedly working in excess of their hours was not a guaranteed staffing cover arrangement.

From a review of the rosters for the two weeks following this inspection, the inspector observed a number of shifts were outstanding to be covered. For example, across the 11 and 12 July 2024, three day shifts and a waking night shift were

required. The assistant manager communicated to the inspector that if necessary they would undertake the shift themselves or the team leaders if required. However, that would mean their attention would be removed from their administration and oversight duties.

The inspector observed that residents were assigned specific staff on a daily basis in order to ensure that the staff member would provide focused care and attention to that resident that they were assigned to.

From speaking with one staff member, two team leaders and the assistant manager, the inspector found that they were familiar with the residents' care and support needs.

Judgment: Substantially compliant

Regulation 16: Training and staff development

From a review of the training matrix and a sample of training certification for staff, the inspector was assured that there were appropriate mechanisms in place to monitor staff training needs and to ensure staff had access to a suite of training in order to support the assessed needs of the residents.

The inspector observed that, staff had received training in areas, such as:

- complaints handling
- medicines management
- fire safety training
- first aid responder
- Autism awareness
- a suite of trainings related to infection prevention and control (IPC)
- epilepsy awareness and emergency medication.

Staff had received additional training to support residents, for example staff had received training in human rights. Further details on this have been included in 'what residents told us and what inspectors observed' section of the report.

The inspector also reviewed supervision files for three staff. The files demonstrated that, supervision arrangements which facilitated staff development were occurring in line with the provider's policy.

Judgment: Compliant

Regulation 23: Governance and management

While there were systems for governance and management in place, further improvement was necessary due to the number of compliance improvements required for other regulations observed on this inspection.

There was a defined management structure in the centre. For example, it consisted of team leaders, an assistant manager, the person in charge, an assistant director and the operations manager, who was the person participating in management for the centre. One staff member spoken with was clear as to the lines of reporting.

There were local and senior management audits completed to assess the quality and safety of care and support provided to residents in the centre. For example,

- a self-assessment tool was completed at the start of July 2024 in order for the provider to assess how they were operating within the regulations
- members of senior management completed monthly quality improvement audits
- the person in charge or assistant manager completed a monthly service report for the assistant director
- there was a schedule of audits set out for 2024. For example, staff training, risk management audits and restrictive practice and incident audits.

The provider had arrangements for unannounced visits and an annual review of the service to be completed as per the regulations. However, while an annual review was completed in 2023 it was not clear when it was completed or for what period it covered. The operations manager believed it took place in May 2023. Another annual review was completed in 2024 which the assistant director confirmed covered the period January 2024 to May 2024. It was heavily focused on the admission of a new resident and was not a thorough overview of the period. This also meant that there was a gap in the review of service for the annual review from May 2023 to December 2023. In addition, there was no evidence of family consultation for either of the annual reviews. Notwithstanding that, there was evidence that the provider was in communication with families through family forums, visits and family were consulted in one of the two unannounced provider lead visits to the centre.

Staff were receiving competency assessments, in medicines management and hand hygiene, from the person in charge or the assistant manager. However, they did not have any additional training to provide them with the knowledge or expertise to carry out those assessments. This was required in order to assure the provider that they were appropriately trained in order to sign staff off as competent in that area.

From a review of the team meetings since January 2024, they demonstrated that they were regularly taking place. However, from a review of the documentation and from discussion with two of the management team, it was not evident if incidents were reviewed for shared learning with the staff team.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider prepared a statement of purpose which was up to date, accurately described the service provided and contained all of the information as required by Schedule 1, for example the staffing arrangements in the centre. While some revisions were required to provide clarity of information, the provider arranged for the revisions to be completed and submitted shortly after the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

For the most part, the provider had arrangements for the submission of notifications as required. While the provider had dealt appropriately with a peer to peer incident that occurred in the centre it had not been notified to the office of the Chief Inspector for Social Services (The Chief Inspector) as required. In addition, some restrictive practices that were in use in the designated centre had not been reported, for example a chemical restraint that was used to support a resident with two healthcare appointments and additionally some window restrictors were in place required to be reported. The assistant manager arranged for the notifications to be submitted within the days following the inspection.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that the residents' needs were being met. However, as previously stated some improvements were required in relation to healthcare, positive behaviour support, communication, premises, fire precautions and medicines management.

Residents were being supported with their healthcare needs, for example to attend hospital reviews as required. However, some improvement was required to one healthcare plan to ensure it adequately guided staff to best support the resident. In addition, improvement was required to the assessment of residents' healthcare needs to ensure all areas are assessed.

The inspector reviewed the arrangements to support residents with their emotional needs and with restrictive practices that were used in the centre. For example, a travel harness was used to support one resident when travelling in a vehicle. For the most part, there were suitable arrangements in place. However, some improvement

was required to ensure restrictive practices were only in place if required and that staff were guided to support residents with all areas of their emotional support needs.

For the most part there were suitable arrangements in place to support residents with their communication needs. However, the inspector observed that further improvement was required. For example, to ensure that residents' communication needs were appropriately assessed by relevant professionals as required.

From a review of the safeguarding arrangements in place, it was evident that the provider had arrangements to protect residents from the risk of abuse. For example, staff had received training in adult safeguarding.

The inspector observed the premises was tidy and in a good state of repair. However, some areas required a more thorough clean.

There was a residents' guide that contained the required information as set out in the regulations.

For the most part, there were suitable fire safety management systems in place, which were kept under ongoing review. For example, the fire detection and alert system was regularly serviced. However, improvement was required in relation to fire drills in order to ensure that everyone could be evacuated at night time and from all doors within the centre if required.

From a review of medicines management, it demonstrated that for the most part there were suitable arrangements in place. For example, medicines had pharmacy labels attached to ensure medication was administered as prescribed. However, improvements were required with the arrangements for the stock check of medicines.

Regulation 10: Communication

From a review of two residents' files, the inspector observed that there was some documented information in residents' personal plans on their communication styles and how best to communicate with them. However, the plans had not been updated in light of some out-of-date information or recently obtained information that had staff had become aware of from getting to know the residents. For example, a plan was not updated to reflect that a staff picture roster was no longer being used for one resident as they did not appear to like when it was put up. This meant that the communication needs were, potentially, not familiar to all staff, to ensure that the residents could communicate appropriately. Notwithstanding that, from speaking with the assistant manager, two team leaders and a staff member, they were familiar with how best to communicate with the residents.

A resident's communication plan did make reference to supporting them with a picture exchange programme. However, staff were found not to be trained in the

use of that picture system to ensure they could effectively support the resident in using the system.

There were picture boards displayed in the centre to facilitate communication. From a review of some of the pictures available in the centre, it was evident that more were required to facilitate menu choices for the residents. It was not evident if residents that required support with their communication were involved in the choice of their meals. From communication with a staff member, they said that staff chose the meals for two out of the three residents.

One resident was referred to a speech and language therapist (SALT) to assess if they required any support with their communication and receptive language. However, two residents, one of which was a recent admission to the centre, had not received SALT input in order to assess their communication needs and supports that they may require. This was in order to assure the provider that supports were being provided in the right manner to adequately support each resident's communication. Therefore, the inspector was not assured that the communication needs of all residents were being appropriately addressed.

The inspector observed that the residents had access to televisions, phones and Internet within the centre.

Judgment: Substantially compliant

Regulation 13: General welfare and development

The provider had ensured that residents had access to opportunities for leisure and recreation. Residents engaged in activities in their home and community and were supported to maintain relationships with family. For example, one resident was supported to re-engage with visiting their family home after long periods of not visiting. They now visited on a weekly basis, often twice a week.

The inspector reviewed the activity planners for two residents for a two week period across June and July 2024 that demonstrated their daily recreation and activities that they participated in. From the sample reviewed, residents were observed to participate in activities based on their interests. For example, residents went for drives, had picnics, attended the library, went shopping, and attended social dances.

While more could be done in relation to supporting one resident with their coping strategies for participating in activities outside of their home and their car, this is being actioned under Regulation 7: Positive behaviour support.

One resident was supported to apply for external day programs and apply for paid employment within the service. They were waiting on feedback from their interview. They communicated to the inspector that they felt hopeful that they got the job as they felt the interview went well.

Residents were supported to come up with goals to work towards during the year. For example, one resident was being supported to explore some college courses and also build on some independence skills.

Judgment: Compliant

Regulation 17: Premises

The premises was observed to be tidy and for the most part clean. The house and apartment were observed to be well maintained on the day of this inspection. There was adequate space for the residents, for example there were multiple communal areas, such as there were two living rooms in the main house and the resident in the apartment had their own private sitting room. Sitting rooms were observed to have different items for use, for example boards games and art supplies. Residents had access to cooking and laundry facilities. Each resident had their own bedroom and some had their own en-suite bathrooms.

However, the inspector observed that some areas required further cleaning to ensure the premises was maintained to a suitable standard for the residents.

Areas included:

- the landing wall had some blood stains on it outside of a resident's bedroom
- one resident's toilet bowl was observed to require cleaning
- the main bathroom required cleaning of the shower enclosure glass, the sink taps, the bath and the corners of the shower enclosure.

Some buckets used for cleaning the apartment were observed to require a more thorough clean and a mop was observed to be stored in a bucket instead of hung up to promote adequate drying. The assistant manager arranged for the mop to be hung and the buckets to be cleaned on the day of the inspection. This required on-going oversight as the inspector had observed similar storage of mops and buckets on the last inspection.

Judgment: Substantially compliant

Regulation 20: Information for residents

There was a residents' guide that contained the required information as set out in the regulations.Foe example, it informed the reader of the visiting arrangements in the centre.

Judgment: Compliant

Regulation 28: Fire precautions

For the most part, there were suitable fire safety management systems in place, including detection and alert systems, emergency lighting and firefighting equipment, each of which was regularly serviced.

The inspector reviewed a sample of two residents' personal emergency evacuation plans (PEEP) and they were observed to be up to date and provided information to guide staff regarding any evacuation supports required. Periodic fire evacuation drills were taking place and the inspector reviewed the documentation of the last four drills. However, there was no evidence of an hours of darkness drill being completed in order to assure the provider that they could safely evacuate all persons at night time. In addition, fire drills did not outline the scenarios that were simulated during each drill. For example, the simulated location of the fire was not recorded. It was not evident if alternate doors were used on different occasions in order to demonstrate that residents could be evacuated from different parts of their home.

The inspector observed that the fire containment door for one resident's bedroom could not close by itself as it was being held open by a chair. The assistant manager removed the chair once this was brought to their attention. They confirmed that a new door hold and release device was purchased for the door and they were awaiting delivery and fitting of it.

Staff completed a range of fire safety checks, for example weekly sounding of the fire alarm.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

For the most part, the inspector found that there were adequate arrangements in place for medicines management within the centre. Prescribed medicines were dispensed by a local pharmacy, and found to be appropriately stored in a locked press in the staff office.

Staff recorded dates of when medicines were opened. That was to ensure appropriate oversight of the medicines stock, as certain medicines had a shorter shelf life once opened and would be less effective past the recommended usage period.

The inspector observed that, medicines due to be returned to the pharmacy were

kept separate from medicines in use until they could be returned.

The inspector observed, from a review of two residents' medicines documentation that an up-to-date prescription was on file for the residents that listed the details of the medicines they were prescribed. Medicines were observed to have pharmacy labels attached to support correct administration as prescribed. However, the pharmacy label for an emergency epilepsy medication did not guide staff that a second dose of the medication could be administered and therefore did not match the direction from the neurologist. That had the potential to mislead staff as to the administration of the medication in the event it was required.

It was not evident to the inspector that a stock count was completed for one resident when medications were removed from the centre for home visits or when they were received back into the centre. This was necessary in order to ensure any inaccuracies in medicines could be rectified as soon as possible in order to prevent medication errors.

Judgment: Substantially compliant

Regulation 6: Health care

From a sample of two residents' files, it was demonstrated that the healthcare needs of residents were being appropriately supported. However, it was not made evident to the inspector if all of their healthcare needs were formally assessed prior to healthcare plans being devised. For example, the inspector did not observe information, such as residents' vaccination status or their last opticians' appointment. This was required in order to assure the provider that all healthcare needs were suitably identified and ensure there were no gaps in the residents' assessed healthcare needs.

There were healthcare plans for identified support requirements in order for residents to experience the best possible health. For example, epilepsy care plans were in place were required. However, one plan did not sufficiently guide staff to all applicable information that staff would require in order to appropriately support the resident in this area if required. For example, it did not guide staff what specific types of seizures the resident may have, how long typically their seizures may last and if there were any known triggers. It did not clarify if the resident was to receive a repeat dose of their if required medication when they were having a seizure.

From a sample of two residents' files with regard to their healthcare appointments, it was evident that residents were facilitated to attend appointments with health and social care professionals as required. For example, the files demonstrated that residents were supported to attend appointments with their general practitioner (GP) and some residents were referred to a dietitian as required to support their healthcare needs.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Where residents presented with behaviour that may cause distress to themselves or others, for the most part, the provider had arrangements in place to ensure those residents were supported. For example, there were positive behaviour support plans in place with information to guide staff as to how best to support the residents. The inspector reviewed a sample of two residents' plans and the plans were all reviewed by a behaviour specialist. However, one resident's plan did not explore how to support them with coping strategies for engaging in activities in the community. The resident was reluctant to leave the centre vehicle and this was impacting on them having a meaningful day despite staff efforts.

There were restrictive practices in place in the centre, for example a locked chemical press and sharps were locked away. They were found to be periodically reviewed and deemed necessary for the safety of the residents. However, the inspector observed some window restrictors in place in two rooms that were not required for the assessed needs of the residents. This required review and removal of the practices if they were deemed not necessary to ensure residents were not being unnecessarily restricted in their home.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to safeguard residents. For example, there was an organisational adult safeguarding policy in place last reviewed in June 2024 and staff were trained in adult safeguarding. One staff spoken with was clear on what to do in the event of a safeguarding concern. Potential safeguarding risks were reported to the relevant statutory agency and a safeguarding plan put in place in order to minimise the chances of further safeguarding risks to the residents.

From a sample of two residents' intimate care plans, the inspector observed that there was clear guidance provided to staff as to how best to support them with regard to the provision of intimate care.

The inspector also reviewed two of the residents' financial safeguards that were in place. The inspector observed that the provider had a system in place that staff checked the money of each resident's money twice a day and any expenditures were recorded. This was in order to ensure their money was accounted for. The inspector checked the balance for the two money boxes and the amounts matched the record. This assured the inspector that there was appropriate safeguards in

place for residents' money.
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	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Substantially compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Tullycoora House OSV-0008059

Inspection ID: MON-0036699

Date of inspection: 09/07/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Recruitment is ongoing, with shortlisting and interviews being scheduled weekly. Three new staff contracted to full time commenced on 05/08/2024. There are also two staff going through onboarding, subject to satisfactory checks, both will be in the post by 01/10/2024. Seven candidates were shortlisted for interviews scheduled for interviewing week commencing 19/08/2024. Recruitment events are being undertaken by the HR Department to enhance the recruitment drive. Staffing deficits are being filled by part-time. The weekly staff hours are monitored are PPIM. Completion date: 15/11/2024	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Annual Review has been updated by the Assistant Director to reflect consultation with family members. Completed: 13/08/2024 All annual reviews carried out going forward will include the entire 12-month period and will be more thorough of each resident and views from family or representatives where applicable. Team meetings include learning event reviews, this process identifies the lessons learnt. Staff are provided with a debrief after each incident and residents also have a debrief of	

the incident where this is applicable. All serious incidents are escalated to the relevant Senior Managers. The Person in Charge and Assistant Manager have been booked on Medication train the trainer a 2-day course that will allow them to carry out medication competency assessments, audits and training of medication face to face with staff.
Completion date: 30/09/2024

All staff are trained in medication administration both through e-learning and face to face. There are medication competencies in place within the Centre's staff files. Staff are signed off after three supervised observations, these are done bi-yearly or where medication issues arise by the Person In Charge and/or staff members Line Manager. Where a medication error occurs, staff undergo refresher medication training and are provided with additional support.
Completed: 13/08/2024 and bi-yearly

Regulation 31: Notification of incidents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
To ensure that all notifications are submitted in a timely manner, Restrictive practices were submitted for Quarter two, and the two chemical restrictive practices were submitted the day after the inspection. Medication was prescribed by the G.P as part of medical intervention. The medication is part of the resident's daily medication and was increased in dosage to allow for the medical intervention.
The Person In Charge will submit all required notifications as per the required time frame. The Assistant Director will monitor weekly.
Completed: 11/07/2024 and as per the notification timeframes.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
New Person-Centred Plan document has been created and issued by the Governance, Quality & Safeguarding Department. The Person in Charge and Key Woker staff will complete for each resident by 30/09/2024.
Completion date: 30/09/2024

Communication plans are under review to add more detail for staff on how the resident likes to be communicated with and how. These will be reviewed by 02/09/2024. The Person in Charge has Sourced Level 1 accredited PECS training for all staff, and this will be delivered over two days and will be completed by 30/09/2024. In the interim we have

created more picture options of food and daily living activities as an informative way to communicate effectively with 2 of our residents, this has enhanced each area for more choices that is person centred to them. This commenced 10.7.2024 and has been added to each week as per service users' needs and wants changing.
Completion date: 30/09/2024/ ongoing

Two residents have been referred to S.A.L.T and are awaiting on appointment. One resident refused to participate in an active S.A.L.T referral that was made prior to admission, they have been deemed to have capacity and this was discussed during a multi-disciplinary meeting with their social worker and nursing professional from the HSE. During resident's meetings each week staff complete a weekly meal planner. The meal planners are not set, and each day residents are offered choice by visuals of the foods that are available from the weekly food shop, staff promote a balanced diet and encourage healthy eating, the residents also have a take away one day a week. Dietician referrals have been made for all three residents.
Completion date: 31/10/2024

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Spot checks are completed daily by Team leaders, Assistant Manager and the Person In Charge. All spot checks are recorded on the daily cleaning schedule. Staff team meeting held on 22/07/2024, included the revised cleaning schedules and reporting of maintenance. The cleaning schedules are overseen by the Team Leaders, Shift Leaders, Assistant Manager and the Person in Charge. Environmental walks are completed weekly by the Person In Charge, Assistant Manager, Team Leaders and the Assistant Director.
Completion date: 19/08/2024 and ongoing

All cleaning identified by the inspector, including the wall with a stain that occurred that day, was cleaned immediately. Bathrooms were also cleaned on the day of the inspection. The mop buckets in the apartment were cleaned out and mop heads were hung up to air dry. The windowsill in the upstairs landing was cleaned and the main bathroom was deep cleaned to include the bath and the water stains on the glass panel.
Completion 09/07/2024 and on going

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire drill documentation is currently being reviewed and will be revise version will be

issued by the Governance, Quality & Safeguarding Department, the documentation will reflect on how to create different fire evacuation scenario including using alternative exit routes. A fire evacuation drill tracker will also be implemented to identify that all staff have participated in a day and night fire drill.
Completion date: 31/08/2024 and ongoing

A nighttime fire drill had been completed within the Centre with residents on the 29/07/2024 and also on the 14/08/2024
Completed: 29/07/2024 & 14/08/2024

Fire door release guards have been put in place on resident's bedroom door and office door.
Completed: 16/07/2024

Fire Safety officer attended service on 01/08/2024 to complete fire inspection, alarms and the doors to ensure they all fully closed when the alarm was set. The Fire Safety Officer conducted an assessment of the kitchen fire door, it was agreed that an intermittent strip will be place down the middle of the door. This work is scheduled to be completed on 20/08/2024.
Completion date: 20/08/2024

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Label for epilepsy medication was changed on 12/07/2024 and collected by staff on 13/07/2024. This now outlines that the rescue medication can be administered a second time if seizure prolongs to 10minutes.
Completed: 13/07/2024

Signing in and out form of medication is in place, staff sign the medication out when going home for visits and sign the medication back in when returning to service. Weekly medication stock checks are done each week and over seen by Person in Charge, Assistant Manager and Team leaders. Epilepsy Support Plan in place to reflect label for rescue medication, and seizure types and triggers. All staff are trained in Buccal Midazolam and Epilepsy awareness; with staff record on seizure activity form when a seizure happens. Neurologist appointment was arranged on 14/08/2024 however awaiting on an updated appointment
Completion date: 31/08/2024

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
An assessment of needs form is in place and is completed when new residents are admitted to the Centre. Following the feedback from inspection the Governance, Quality & Safeguarding Department are currently reviewing this document to expand on national health screenings, smear tests, vaccination etc. This will allow to have an overall insight of each resident's health and when they are due for medical reviews. This will be in place by 30/09/2024.
Completion date: 30/09/2024

Each resident has a yearly medication review by the G.P, they also have PRN medications reviewed, and signed six monthly by their G.P. Each resident is supported to attend G.P appointments when required. There is a health action plan in place, and this is a live document where staff update this as the residents attend appointments and when they are due back for appointments relating to active health problems or concerns. Staff also complete pre and post consultation forms after each appointment with medical professionals.
Completion date: ongoing

One residents' epilepsy support plan has been revised to include the administration of rescue medication Buccal Midazolam in the event of a seizure, as stated under regulation 29. This will be reviewed again once the appointment with the neurologist consultant is undertaken, expected to be in September 2024. The support plan guides staff to identify the type of seizure, for example tonic clonic and absent seizures. What is a possible trigger for seizure for example, missed medication, interrupted sleep patterns and symptoms of being unwell. How to support during and after a seizure and where to record the seizure and who to report to when a seizure occurs. Emergency protocols are also identified in the event that the rescue medication does not take as prescribed. All staff are trained in Epilepsy awareness and Buccal Midazolam.
Completion: 10/07/2024

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The inspector had identified that window restrictors were placed on 2 windows in the main house's second Livingroom, and one service user's bedroom which were not applicable and were removed the next day after inspection.
Completion 10/7/2024

All restrictive practices within the service are person centered to each resident and reviewed with multi-disciplinary professionals 3 to 6 monthly.

PBSP are currently being revised and input has been sought from the positive behaviour specialist who will work closely with residents to create more meaningful activities including getting one resident out of the vehicle when in the community. Time frame below as this will take time working alongside our service user consistently to achieve this goal.
3-6months minimum 31.10.2024 maximum 31.01.2025

There are PBSP in place for each resident to support staff when working with residents. Staff complete ABC charts, which allow the positive behavioural support specialist to review to determine patterns of behaviour and communication.
Completion date: 30/9/2024 and ongoing

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	30/09/2024
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	01/10/2024
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in	Substantially Compliant	Yellow	01/10/2024

	circumstances where staff are employed on a less than full-time basis.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	01/10/2024
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	01/10/2024
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	09/08/2024
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	09/08/2024
Regulation	The registered	Substantially	Yellow	30/09/2024

23(3)(a)	provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Compliant		
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.	Substantially Compliant	Yellow	11/09/2024
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and	Substantially Compliant	Yellow	13/07/2024

	to no other resident.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Substantially Compliant	Yellow	11/07/2024
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Substantially Compliant	Yellow	11/07/2024
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	30/09/2024
Regulation 07(3)	The registered provider shall	Substantially Compliant	Yellow	31/01/2025

	ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	30/10/2024