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

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| Name of designated centre: | Liffey 8 |
| Name of provider: | St John of God Community Services CLG |
| Address of centre: | Dublin 8 |
| Type of inspection: | Unannounced |
| Date of inspection: | 26 September 2024 |
| Centre ID: | OSV-0008307 |
| Fieldwork ID: | MON-0043733 |

## About the designated centre

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

Liffey 8 is a designated centre operated by St. John of God Community Services CLG. The centre located on the provider's campus setting in Islandbridge. Residents in Liffey 8 have a moderate to profound intellectual disability and have support needs in the areas of behaviours of concern, sensory needs, communication and specific dietary requirements. Residents are provided with their own bedroom, a living room and a kitchen as well as a small courtyard, and they are supported to access facilities in the community and those available on the provider's campus. Residents have access to multidisciplinary allied professionals through the provider's own clinical team as well as community allied health care professionals. The centre is staffed by a team social care workers who report to the person in charge.

**The following information outlines some additional data on this centre.**

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| 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 |
|---|---|---|---|
| Thursday 26 September 2024 | 10:00hrs to 17:00hrs | Jennifer Deasy | Lead |

## What residents told us and what inspectors observed

This inspection was an unannounced inspection scheduled to monitor the provider's progress in coming into compliance with the regulations and standards. This centre has been subject to enhanced monitoring within the current regulatory cycle due to non-compliances identified on previous inspections and some unsolicited information received from concerned stakeholders. The current inspection found that the provider was making good progress in implementing their action plans and in coming into compliance. Overall, a high level of compliance was identified on this inspection and residents were seen to be in receipt of a good quality service.

The designated centre is located on the provider's campus in Islandbridge. It is comprised of two houses which altogether are home to three residents. These residents had all transitioned to this centre from a larger, congregated setting on campus within the past two years. One house is home to one resident and the other one is home to two residents. The residents' houses were seen to be clean and comfortable. The inspector saw, on arrival to the centre, that both houses had been fitted with new front doors and that blinds had been installed to ensure one resident's privacy from the car park located outside. Some windows in both houses had also been replaced since the last inspection. The houses were well-maintained to the exterior.

Inside, they were seen to provide adequate private and communal space for the residents. Each resident had their own bedroom and there were sitting rooms, kitchen and laundry facilities. Residents had access to bathrooms which were clean and suitable to meet their needs.

The inspector spoke with three staff over the course of the day and to the person in charge. They each told the inspector of the positive impact that the designated centre was having on the lives of the residents that they supported. For example, in one house, the quieter living arrangement and the more consistent staffing levels had resulted in the resident feeling less anxious and there had been a reduction in incidents of self-injurious behaviour. Additionally, the provider had recently reviewed the restrictive practices for the centre and had identified that one restrictive practice was no longer required and therefore was removed from the resident's behaviour support plan. This was evidence that the provider was ensuring that residents' rights were being upheld in their homes.

A staff member for this house told the inspector that the resident seemed happier, that they were smiling more often and were interacting more with staff. For example, staff said that the resident allowed staff to sit with them and watch football together. Previously, the resident had preferred their own company and had limited interaction with staff. The staff member spoke positively about the resident, telling the inspector "when [the resident] laughs, it's the nicest thing to see".

In the other house, the inspector met with a staff member who had worked with

one of the residents for many years. They told the inspector that they had seen positive impacts for the residents upon their transition to the smaller designated centre. For example, residents looked well, were getting out in the community more often, going on holidays and participating in more activities. Staff told the inspector that the move to smaller houses had resulted in more positive mealtime experiences for one of the residents. The resident's appetite had improved and as a consequence, their dietetic care plans were revised and it was determined that they no longer required nutritional supplements.

The inspector saw and heard friendly and familiar interactions between staff and residents. Staff spoken with were knowledgeable regarding residents' needs and preferences. Staff in one house were seen to respond to a resident's verbal requests for a treat to go with their cup of tea. Staff in another house clearly understood a resident's non-verbal requests for a back rub and were seen to facilitate this in a kind manner.

Staff spoken with told the inspector that they had received training in human rights. Staff told the inspector that they ensured residents' rights were upheld by communicating clearly with residents about their care before providing it and checking for consent. Staff said that they offered residents choices and put the residents at the centre of decision making.

The inspector met all three of the residents. One resident acknowledged the inspector and agreed to allow her to see their house. This resident was seen to be well-dressed and was listening to music and completing a puzzle. There was a visual schedule in place which showed the plans for the day. These included going for a walk and to the gym.

Another resident engaged with the inspector in non-verbal means and this was supported by staff. The resident was seen to be supported by staff to transfer from their wheelchair to a comfy chair and they were given sensory activities to enjoy while waiting for dinner. The third resident did not engage with the inspector but the inspector saw that they appeared familiar with the staff and that there were gentle and respectful interactions between the staff and the resident.

Overall, the inspector found that the move to smaller houses from a congregated setting had a positive impact on the residents' quality of life. Residents were in receipt of more person-centred care, were engaging in activities of their choosing and there were evidenced positive impacts on their health and well-being. For example, an increase in residents' weight resulting in the elimination of nutritional supplements and the elimination of a restrictive practice due to a reduction in anxiety. The next two sections of the report will describe the oversight arrangements and how effective these were in ensuring a good quality and safe service.

## Capacity and capability

This section details the governance and management arrangements and describes how effective these were in ensuring the quality and safety of care. This inspection found that the local management systems and the staffing levels required enhancement however overall, the provider and person in charge were endeavouring to provide good quality care and support and had implemented interim arrangements while waiting on vacant posts to be filled. These were generally effective in ensuring residents were in receipt of a good quality service.

There were defined management systems in the centre. The staff team ordinarily reported to a social care leader, who in turn reported to a person in charge. However, a vacancy in the social care leader role had resulted in increased responsibilities for the person in charge. The person in charge also had responsibility for another designated centre which was located on the campus and was responsible, as a senior manager for a third designated centre. Ordinarily, if there was a social care leader in place, the inspector was told that they would complete staff meetings, supervisions, carry out local audits and submit monitoring notifications to the Chief Inspector of Social Services. However, with the vacancy these responsibilities were assigned to the person in charge.

This inspection found that the gap in the management systems was resulting in some areas of non-compliance with the regulations. For example, not all quarterly notifications had been submitted as required and some of the residents' care plans had not been reviewed within 12 months. Audits which were normally completed by the social care leader had also not been completed within the defined time frame. For example, an infection prevention and control (IPC) audit was completed in July 2023 and detailed that the next audit was scheduled to take plane in January 2024 however there was no record of this audit having been completed.

The staff team told the inspector that the person in charge was available to them and that they had good systems in place for local communication, such as using communication books and emails. However, they had limited formal support as a result of the social care leader vacancy. For example, staff said that staff meetings were infrequent in one of the houses. The inspector reviewed the meeting records and saw that there had been a staff meeting in August 2024 but no other meetings were recorded for that house. The person in charge stated that other meetings had occurred however there were no records available to review.

There was a very high level of compliance with mandatory and refresher training across the staff team. The inspector saw that all staff were up to date with training in key areas as required to meet the residents' needs. Staff were informed of the provider's policies and of their designated roles and responsibilities. Staff stated that the management team were responsive and they were satisfied that they could raise any concerns to the person in charge.

While there was a gap identified in the management systems, this was not found to be having any significant impact on the quality of care for the residents. However, the management systems required enhancement to ensure the ongoing oversight of the safety of care and compliance with the regulations.

## Regulation 15: Staffing

The designated centre was operating with a number of vacancies at the time of inspection. This was found to be impacting on the continuity of care for residents in one of the two houses.

In the first house, the provider had implemented systems to ensure that, as often as possible, a 0.2 whole time equivalent (WTE) vacancy was filled by regular staff who worked overtime to fill the shift. The provider had also identified a list of 12 agency staff who had completed an induction and were familiar with the resident's needs. While there were 12 agency staff available to the centre, the inspector saw, on a review of the roster, that gaps were usually filled by regular staff working overtime. This was effective in ensuring continuity of care for the resident.

In the second house, which was home to two residents, there was one WTE vacancy for a staff nurse. This had resulted in a reliance on relief and agency staff to fill the roster. For example, in September, 16 agency or relief staff were required to fill 20 shifts. The person in charge had put in place systems to try to ensure the quality of care when relief staff were on duty, for example agency staff were rostered on with permanent staff. However, the high use of relief and agency was not effective in ensuring continuity of care for the residents.

The centre was also operating with a social care leader vacancy which was impacting somewhat on the oversight of care. This will be discussed under Regulation 23.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

There was a very high level of compliance with mandatory and refresher training. All staff had received and were up-to-date with training in areas such as first aid, positive behaviour support, safe administration of medications (SAMs) and infection prevention and control (IPC).

Judgment: Compliant

## Regulation 23: Governance and management

There were clearly defined management systems in place however a vacancy in the local management arrangements had resulted in gaps in the oversight of the centre.

These gaps included:

- local infection prevention and control audits had not been completed within the time frame that was allocated
- some of the residents' care plans had not been reviewed within 12 months
- notifications had not been submitted as required by the regulations
- staff meetings were not occurring as frequently as the person in charge would like and the records of these meetings were not adequately maintained.

These gaps were not found to be resulting in medium or high risk to the residents. For example, the inspector saw that in spite of IPC audits not being completed, both houses were very clean and well-maintained. Staff members were well-informed of the residents' care plans and the inspector saw and was told that some care plans, for example, dietetic care plans and behaviour support plans, had been reviewed and updated. While staff meetings were not occurring regularly, the staff team told the inspector that the management team were responsive and easy to contact. However, enhancements were required to the local management systems to ensure that the service was consistently and effectively monitored and continued to be appropriate to meet the residents' needs.

The inspector reviewed the most recent six-monthly unannounced provider audit from April 2024. This audit was seen to be comprehensive and clearly reflected the presenting risks in the service. For example, the audit had identified that a gap in the local management arrangements had resulted in an expansion of the person in charge's roles and responsibilities which was linked to some gaps in the oversight of the service. An action plan was implemented in this regard and the inspector was informed that the provider had prioritised the recruitment of a social care leader for the service.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

The inspector reviewed a log of adverse incidents and events and found that there were two quarterly notifications in respect of the following incidents which had not been notified to the Chief Inspector in line with the requirements of the regulations:

- notification of any unplanned evacuation of the centre: it was documented in the provider's six-monthly unannounced visit that the fire alarm in one of the houses had activated on eight occasions in late 2023 and that this had resulted in unplanned evacuations. However, the required notifications were not submitted
- notification of minor injuries: a number of minor injuries for one resident had not been notified in line with the requirements of the regulations

Judgment: Not compliant

## Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived in the designated centre. This inspection found that residents were in receipt of a very good quality and safe service. Residents were seen to be living in safe premises and were supported by staff who knew their needs and preferences well. Residents were in receipt of person-centred care which was providing them with opportunities to develop and maintain relationships with their community and family.

The designated centre was seen to be homely and comfortable. The provider had completed works subsequent to the last inspection which had been effective in making the centre more homely. For example, new front doors and blinds were installed and a rubbish disposal area was fenced off so it was out of sight. The premises of the centre was designed and laid out for accessibility. The centre was also fitted with appropriate fire detection, containment and extinguishing facilities. Staff spoken with were well-informed of the fire evacuation procedure and the inspector saw, through reviewing records, that all residents could be evacuated in a safe time frame in the event of an emergency.

Residents had access to their own money for their personal spending and for their activities. Staff spoken with were well-informed of the provider's policy and procedure for managing residents' finances. The inspector saw, through reviewing records, that residents used their money for a variety of social and recreational activities including going for dinner, reflexology and music therapy.

Residents in this centre had opportunities for occupation and recreation. Some residents accessed day services while one resident had their own individualised service. Residents were supported to access their community and to go on holidays.

Staff were well-informed of residents' care plans, and in particular, their behaviour support care plans. Staff had received training in behaviour support and could describe to the inspector how they ensured that restrictive practices that were prescribed were the least restrictive and used for the shortest duration. The inspector was also told that, due to the move to the smaller house, one resident, who had been prescribed a restrictive practice to manage anxiety and associated challenging behaviour in one particular situation, no longer required this restriction.

There were appropriate safeguarding procedures in place in the centre and staff were informed of their roles and responsibilities in this regard. There were also detailed care plans on residents' files describing how staff were to provide care to residents in a manner that upheld their privacy and dignity.

## Regulation 12: Personal possessions

The provider had effected policies and procedures to ensure that residents had access to their personal finances. Staff were informed of the provider's policy and of the local operating procedure in managing residents' finances. A review of one of the resident's expenses showed that they used their money for a variety of personally relevant social activities. Regular audits of residents' finances were completed and action plans were implemented to address any issues identified as a result of the audits.

Records of residents' possessions were maintained and the inspector saw that residents had access to their personal possessions in their homes.

Judgment: Compliant

## Regulation 13: General welfare and development

Residents had opportunities for activation and relaxation in line with their personal preferences. Some residents accessed day services while one resident received an individualised day service from their home. On the day of inspection, some residents had been swimming with their day service while another resident had plans to go for a walk and to the gym.

Staff members told the inspector of the many activities which residents enjoyed including music therapy, reflexology as well as going out for dinner and drinks in local pubs and restaurants. Staff were proactive in their approach to managing risk and ensured that residents' needs did not impact on their ability to access preferred activities. For example, one staff member told the inspector of how they brought a medication required to thicken fluids to the pub so that a resident could enjoy a pint of Guinness.

Residents were supported to maintain relationships with their families. Staff members told the inspectors of how residents enjoyed having their family visit them in their homes.

Judgment: Compliant

## Regulation 17: Premises

The premises of the designated centre was very clean and well-maintained. The provider had completed works to the premises subsequent to the last inspection. These works were effective in improving the homeliness of the centre and

enhancing the privacy for residents. For example, new front doors and windows had been installed along with blinds for privacy. An area used for rubbish disposal had been fenced off so it was not visible from one of the houses.

The houses were personalised with residents' photos and belongings. Residents each had their own bedroom which was decorated in line with their personal tastes. There was sufficient storage for storing residents' personal belongings. The premises of each of the houses were fitted with laundry facilities, cooking facilities and sitting rooms. The premises were also designed and laid out to meet the assessed needs of residents. For example, accessible wet rooms were in place and corridors were wide enough to accommodate mobility aids.

Judgment: Compliant

## Regulation 28: Fire precautions

The provider had ensured adequate fire safety management systems were in place in the centre. The provider had addressed areas of non-compliance in respect of fire safety as identified on the last inspection of the centre. For example, a repeater fire panel had been installed in one of the houses of the centre. This was seen to be working on the day and had been recently serviced. Staff spoken with were aware of it's location and of how to carry out a fire drill in the centre.

The provider had completed regular fire drills with residents. The records of these drills were reviewed. It was found that all residents could be evacuated in a timely manner in the event of an emergency with the minimum number of staff on duty as detailed on the roster.

The inspector reviewed the personal evacuation plan for one resident and saw that it was up to date and clearly detailed the supports required to evacuate the resident.

The houses that comprised the designated centre were fitted with equipment to detect, contain and extinguish fires. For example, fire doors with automatic door closers were installed, along with fire extinguishers and fire blankets.

Judgment: Compliant

## Regulation 7: Positive behavioural support

Staff had received training in positive behaviour support and were informed regarding residents' behaviour support needs and their associated care plans. The inspector reviewed one of the resident's files and saw that they had an up-to-date behaviour support plan which detailed proactive and reactive strategies to support

residents.

There were a number of restrictive practices in place in the centre. These were reviewed regularly by the provider's rights committee. The inspector was told that one restrictive practice had recently been eliminated as it was no longer required due to a decrease in the resident's anxiety around a specific occasion. Staff were clearly informed of other restrictive practices and gave information to the inspector on how these were used for the shortest duration and in the least restrictive way possible. Staff were clear on the need to use proactive strategies in the first instance to prevent responsive behaviour from occurring.

Judgment: Compliant

## Regulation 8: Protection

All staff in this centre were up to date with training in mandatory areas including safeguarding vulnerable adults and Children First. Staff were informed of the safeguarding procedures and of how to report safeguarding concerns to the designated officer. The inspector saw that where safeguarding concerns had been identified these were screened by the designated officer and were reported to the statutory authorities. Safeguarding plans were implemented to protect residents and the provider had investigated any allegations of abuse.

The inspector saw that a resident's file contained an up-to-date intimate care plan which was written in a person-centred manner. The intimate care plan provided guidance for staff on delivering care in a manner which upheld resident's autonomy, privacy and dignity.

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 31: Notification of incidents | Not compliant |
| **Quality and safety** | |
| Regulation 12: Personal possessions | Compliant |
| Regulation 13: General welfare and development | Compliant |
| Regulation 17: Premises | Compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 7: Positive behavioural support | Compliant |
| Regulation 8: Protection | Compliant |

# Compliance Plan for Liffey 8 OSV-0008307

## Inspection ID: MON-0043733

## Date of inspection: 26/09/2024

**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:<br>• The Social Care Leader vacancy is under active recruitment and due to close on the 21st of Oct 2024. Time Frame:31/01/2025 (inclusive of successful interview, recruitment requirements and induction to the service)<br>• Staff vacancies are under active recruitment. Time Frame:31/01/2025 (inclusive of successful interview, recruitment requirements and induction to the service). | |
| Regulation 23: Governance and management | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>• The Social Care Leader (SCL) vacancy is under active recruitment and due to close on the 21st of Oct 2024. Time Frame:31/01/2025 (inclusive of successful interview, recruitment requirements and induction to the service).<br>• Staff vacancies are under active recruitment. Time Frame:31/01/2025 (inclusive of successful interview, recruitment requirements and induction to the service).<br>• Staff Meetings will be scheduled on a bimonthly basis until the SCL commences and then the meetings will be monthly. Time Frame: Completed.<br>• Infection Control Audit has been completed and will be completed monthly by the frontline team and reviewed by the PIC. Time Frame: Completed.<br>• Notifications will be submitted to HIQA as required on the HIQA portal. Time Frame: as required notifications will be submitted.<br>• Care Plans will be reviewed by the residents' keyworkers to ensure they are within the 12-month time frame. Care plans will be amended in line with the residents needs. Time Frame: 31.10.24. | |

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| Regulation 31: Notification of incidents | Not Compliant |
| Outline how you are going to come into compliance with Regulation 31: Notification of incidents:<br>• Notifications will be submitted to HIQA as required by the PPIM/PIC on the HIQA portal. Time Frame: as required notifications will be submitted. | |

## Section 2:

## Regulations to be complied with

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

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

| Regulation | Regulatory requirement | Judgment | Risk rating | Date to be complied with |
|---|---|---|---|---|
| Regulation 15(3) | The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis. | Substantially Compliant | Yellow | 31/01/2025 |
| 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 | 31/10/2024 |
| Regulation 31(1)(c) | The person in charge shall give the chief inspector notice in writing within 3 working days of the | Not Compliant | Orange | 31/10/2024 |

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| | following adverse incidents occurring in the designated centre: any fire, any loss of power, heating or water, and any incident where an unplanned evacuation of the centre took place. | | | |
| Regulation 31(3)(d) | 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 injury to a resident not required to be notified under paragraph (1)(d). | Not Compliant | Yellow | 31/10/2024 |