Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Children).

Issued by the Chief Inspector

Name of designated centre:	Ardchros
Name of provider:	Talbot Care Unlimited Company
Address of centre:	Louth
Type of inspection:	Announced
Date of inspection:	01 October 2024
Centre ID:	OSV-0008723
Fieldwork ID:	MON-0043245

About the designated centre

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

Ardchros provides residential care to six children between the ages of 8- 18 years old. It comprises of three two bedroom terraced houses. Each house comprises two bedrooms on the first floor, a shared bathroom and a sensory room. In one of the houses there is also an office upstairs. Downstairs in each of the houses there is a spacious kitchen/dining area, a small utility area, a sitting room and a toilet. To the back of each of the house there is a garden which contains a trampoline and a large swing. The staff compliment consists of direct support workers, social care workers and a child care practitioner. The person in charge works Monday to Friday and is also supported in their role by two senior social care workers and a team leader. There are two vehicles provided between the three houses so as residents can go to school or do activities.

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 1 October 2024	10:40hrs to 17:50hrs	Anna Doyle	Lead

What residents told us and what inspectors observed

This inspection was announced. The centre was registered in March 2024 following a review of information and a site inspection by the Health Information and Quality Authority, the Chief inspector granted the application to register the centre for six residents. The purpose of this inspection was to assess how the service was operating in compliance with the regulations and standards. At the time of this inspection only three residents were living in the centre. One resident lived in each house and this was in line with the residents needs at the time of this inspection.

Overall, the inspector found that the residents living here were being provided with an individualised, bespoke service based on their assessed needs. Staff were observed to treat residents in a kind manner and were focusing on improving their quality of life. However, some significant improvements were required in two regulations which related to governance and management and positive behaviour support. Some improvements were also required in general welfare and development, risk management, residents personal plans and medicine management.

On arrival to the centre, the inspector noted that one of the resident's had left to attend school, and the other two residents were engaged in some activities with the staff. The inspector only met two residents as the other resident had not returned from school by the end of the inspection. However, the inspector did see pictures of this resident enjoying numerous outdoor activities with staff which they looked like they were enjoying.

Each of the three houses were spacious, clean and finished to a very high standard. Residents had their own bedrooms which were decorated in line with their preferences and needs. For example; one resident liked a particular cartoon character and there were pictures of the cartoon character on the bedroom wall. In all three of the houses, communication aids in the form of visual schedules were in place for each resident. The pictures of staff who were working very day was also on display to inform the residents regarding who would be supporting them.

Each house had a sitting room which had a large TV and one resident was observed relaxing on the floor watching their favourite programmes.The kitchen was large, well equipped and there was pictures on the wall showing residents what was for dinner and lunch that day. The staff were aware of the residents food preferences and meals were chosen with the residents each week. Sometimes the residents did not like to engage in this process and staff informed the inspector they chose the residents meals based on the residents known preferences.The inspector also observed some communication aids (visual schedules) where residents could choose what snacks and drinks they would like during the day. This was an example of how residents choices were promoted in the centre.

There was also a sensory room in each house and two of the residents were observed using this over the course of the inspection. One resident was observed sitting with staff engaging in some sensory play activities, while the other liked to spend time on their own in the sensory room, where they were observed enjoying the lights and some sensory toys. One of the residents liked swimming and went with staff to a local swimming pool on the day of the inspection. Another resident went for a drive which they enjoyed doing.

The residents were supported to keep in touch with family members and families could visit the centre whenever they wished to. One staff member explained how family members were kept informed about the residents care.

Two staff members who spoke to the inspector were aware of the assessed needs of the residents. For example, one resident had a specific medical condition that required a high fibre diet and one staff spoke about the importance of this. The other staff showed the inspector the communication aids in place for all of the residents in each house.

The three residents living in the centre used non verbal cues and aids to communicate their needs. For example; visual schedules were in place and staff informed the inspector that, residents would physically direct staff to something they wanted. All three of the residents displayed some behaviours of concern and had behaviour support plans in place to guide staff practice and ensure that the residents were being supported with their assessed needs. However, the inspector found that there were significant differences in what was included in the behaviour support plans and the practices in the centre. This did not assure consistency of care to the residents. This is discussed in more detail under the quality and safety section of this report.

Staff spoken with outlined some of the activities that the residents liked to do such as sensory play, using the trampoline, the sensory room and some of the residents enjoyed listening to music or watching their favourite cartoons on television.

At the time of the inspection two residents did not have a school placement and the staff were trying to provide a structured, meaningful day for the residents. For example; one of the staff explained that, one resident liked to do some structured table top activities for a short time and then have time in the sensory room and they also liked to go for a drive. While the person in charge was trying to source a school placement for the residents, they had not been successful in securing a placement at the time of this inspection.

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

Capacity and capability

The person in charge met with the inspector to go through the governance and management arrangements in the centre and to discuss some aspects of the residents care and support needs. The inspector also met with the director of services, who is a person participating in the management of the centre.

Overall, the inspector found that while there were governance and management structures in place in the centre to oversee the care and support provided, some of these oversight arrangements were not identifying areas that required improvement. The inspector found that, improvements were required in medicine management practices as discussed under regulation 23, the provision of positive behaviour support, risk management, assessments of needs and the educational needs of the residents.

The management structures in place included a full time person in charge. They reported to an assistant director of services whom they met every month to review the quality of care and services being provided. The registered provider had systems in place to review and audit services, however these audits were not identifying some of the improvements required found on this inspection. For example; an audit conducted in the centre on medicine management practices found that, this regulation needed minor improvements, yet on further investigation, the inspector found that some medicine management practices were not in line with best practice guidelines. This is discussed under regulation 23 as the inspector did not review all aspects of medicine management practices in the centre.

There was a planned and actual staff roster maintained in the centre and a review of a sample of weeks showed that the staffing arrangements were in line with the assessed needs of the residents.

Staff had been provided with mandatory training in order to support the residents needs in the centre and assure a safe service.

Regulation 14: Persons in charge

The person in charge was employed on a full time basis in the organisation.They were, an experienced social care professional with a qualification in management. They were also supported by two senior social care workers and a team leader who had some managerial responsibilities. For example; the team leader did some of the staff supervision.

The person in charge was found to be responsive to the inspection process and to meeting the requirements of the regulations. They had systems in place for the oversight and management of the designated centre in line with the providers policies and procedures.They were also aware of their legal remit under the

regulations and provided good leadership to their staff team and ensured that staff were supported through regular team meetings.

Judgment: Compliant

Regulation 15: Staffing

There was a planned and actual staff roster maintained in the centre. The inspector reviewed a sample of rosters in August and September 2024 and found that, the staffing levels were maintained in line with the residents assessed needs. The skill mix of staff included, direct support workers, social care workers and a child care practitioner. The staff numbers included; six staff each day and five waking night staff between the three houses. Regular relief staff were also employed if required to cover planned or unplanned leave.

Nursing supports were also available from community nurses who were employed in the wider organisation and a senior nurse manager was on call at night to provide assistance if required.

All new staff had completed induction with the person in charge or a team leader/senior social care worker. A review of a sample of supervision/induction records showed that staff were able to raise concerns in the centre. They were also able to discuss their personal development.

The two staff who spoke to the inspector were aware of the residents health care needs and discussed some of the communication supports in place for residents.

Judgment: Compliant

Regulation 16: Training and staff development

A review of the staff training records showed that, staff were provided with mandatory training and some training that was specifically required to work in this designated centre.

For example, staff mandatory training included the following:

- Adult Protection
- Positive Behaviour Support
- Positive Management of Complex Behaviours
- Fire Safety
- Manual Handling
- Infection Control
- Children's First

- Human Rights-based Approach in Health and Social Care Services
- First Aid
- Safe administration of medicines.

The person in charge informed the inspector that, the registered provider was also rolling out new training called basic life support training for all staff.

Two staff members who spoke to the inspector were aware of the assessed needs of the residents. For example, one resident had a specific medical condition that required a high fibre diet and the staff spoke about the importance of this.

Judgment: Compliant

Regulation 23: Governance and management

There was a defined management structure in the centre led by a person in charge who worked on a full time basis in this centre.

The registered provider had systems in place to audit and review practices in the centre. For example; the person in charge completed a number of audits each month to ensure that best practice was maintained. The assistant director of services also visited the centre each month to discuss the care and support being provided in the centre. During these visits the assistant director also completed some audits. A review of a sample of those self audits showed that minor improvements were required in some areas.

However, the inspector reviewed a medicine audit that had been conducted in the centre and when following up on actions from this audit, they found that medicine management practices in the centre required significant review.

For example; the registered provider and key senior managers were aware that some medicine administration records (kardex) were not signed by the prescribing doctor. When the inspector requested the policy and procedure to guide practice in relation to this, there was none available. The person in charge went through the practice, and the inspector was not assured that this was in line with safe practices. For example; a nurse typed up the medicine kardex with the prescription provided by the general practitioner (GP) however, there was no record to verify that it was a nurse who completed this.

In addition one of the typed medicines on the kardex did not have a corresponding prescription from the GP. For example; paracetemol was typed on the kardex for a resident but was not on the prescription attached. The inspector reviewed the medicine for one resident and was not assured from talking to staff that the correct dose of medicine was in the blister pack. To mitigate the risk the team lead brought the medicine blister pack to a local chemist to verify that the correct dose of

medicine was in the pack. The inspector was assured before leaving the centre that this medicine dose was correct.

Given these findings, the inspector found that medicine management practices needed to be reviewed as the system in place posed a potential risk that residents may not be getting the correct medication or dosage of medication.

Staff meetings were held regularly in the centre. A review of a sample of these records showed that at each meeting, staff were asked if they had any concerns. No concerns were noted from the records viewed.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed and was found to meet the requirements of the regulations.

This document detailed, the aim and objectives of the service and the facilities and services to be provided to the residents.

The provider and person in charge was aware of the requirement to review and update the statement of purpose on an annual basis (or sooner), as required by the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector reviewed a sample of the incidents that had occurred in the centre since the centre opened and found that the person in charge had notified the office of the Chief Inspector of any adverse incidents occurring in the centre in line with the regulations.

This assured the inspector that the person in charge was aware of their remit under the regulations to report adverse incidents.

Judgment: Compliant

Quality and safety

Overall, the inspector found that residents were provided with a bespoke service at the time of the inspection. The staff team were providing individualised supports to each resident and the residents appeared comfortable in their new homes. Notwithstanding, as discussed improvements were required in general welfare and development, risk management, the review of residents care and support needs and positive behaviour support.

Resident personal plans were reviewed and It was evident on review of some of the records and from talking to staff and the management team that there had been some positive improvements in the quality of life of the residents since moving to the centre. As an example; recently there had been a reduction in the number of incidents relating to behaviours of concern in the centre.

The arrangements in place for the provision of positive behaviour supports required improvements. The inspector observed that what was written in the plans was not always the practice in the centre. Other improvements were also required to ensure that where incidents of behaviours of concern did occur that they were reviewed.

Each resident had a personal plan in place which included an assessment of need. One residents assessment required amendments as it contained information that was not correct or verified by a competent professional. This was discussed with the person in charge. In addition, some improvements were required to the review of residents care in the centre.

Risk management systems in the centre also required review to ensure that trending and reviews were conducted to inform further learning.

The staff supported residents to have meaningful days, however, at the time of this inspection, two residents did not have a school placement and this required attention.

Regulation 13: General welfare and development

There were opportunities for the residents to engage in activities outside their home. For example on the day of the inspection, one resident went swimming which they really enjoyed and another resident went for a drive. One of the residents went to school. The inspector also saw some photographs in each house showing some of the community activities that residents had enjoyed since moving to the centre.

The staff also outlined some of the activities that the residents liked to do such as sensory play, using the trampoline, the sensory room and some of the residents enjoyed listening to music or watching their favourite cartoons on television. In the absence of a school placement for two of the residents the staff were trying to provide a structured meaningful day for the residents. For example; one of the staff

explained that a resident liked to do some structured table top activities for a short time and then have time in the sensory room.

However, as stated at the time of this inspection two of the residents did not have a school placement. The inspector found that looking for a school placement for the residents had not being considered prior to the residents moving to the centre and therefore had not been addressed in a timely manner by the registered provider.This required review.

Judgment: Substantially compliant

Regulation 17: Premises

Each of house of the three houses were spacious, clean and finished to a very high standard. Residents had their own bedrooms which were decorated in line with their preferences and needs.

Each house had adequate communal space for the residents such as a sitting room and sensory room. The kitchen was large clean and well equipped.

To the back of each house there was a garden area where outdoor facilities were provided such as as trampoline and swing.

The registered provider had systems in place to ensure that the premises were maintained to a good standard and that equipment stored there was also in good working order.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a risk management policy in place to guide and inform the management of risks in the centre. However, some improvements were required to this process.

The registered provider had a system in place to review adverse incidents in the centre. When an adverse incident occurred, it was reviewed by the person in charge, then by the assistant director of services and then by the health and safety committee in the organisation.

However, while the person in charge reviewed adverse incidents and made some recommendations to inform further learning this was not always transferred over to the risk assessment for the resident. For example; there was an incident where a resident attempted to leave the centre unaccompanied by staff which could have put them at risk. The person in charge recommended further actions to address this.

However, the risk assessment in place to manage this did not include the specific measures in place to mitigate this risk and so required review.

The inspector also found that there had been 71 incidents which related to behaviour of concern in the centre since it had opened. And as actioned under regulation 7 there had been no review of these incidents to inform future learning. This required review.

In addition, there was no report from the health and safety committee in the organisation to see the outcome of their review and trending of incidents that had occurred in this designated centre.

The registered provider had a number of checks in place to ensure that some risks were managed in the centre. For example; the water temperature in the centre was checked to ensure that the correct temperature was maintained.

Overall the inspector found that the registered provider had systems in place to manage risks in the centre, however, improvements were required to ensure that incidents were reviewed to inform further learning.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were systems in place to manage and/or prevent an outbreak of fire in the centre. The inspector reviewed the fire safety records in one house and the fire drills and personal emergency evacuation plans (PEEPS) for each of the three houses. Fire equipment such as emergency lighting, a fire alarm, fire extinguishers and fire blankets were provided and were being serviced regularly. For example; emergency lighting and the fire alarm was required to be serviced every three months. The records showed that this had been completed in August 2024. The fire extinguishers had been checked in May 2024.

The staff also completed periodic checks to ensure that effective fire safety systems were maintained. For example; the staff checked that escape routes were kept clear each day. Six monthly checks were also completed on the fire doors to ensure that fire seals were intact and they were in good working order. From a review of a sample of these records, the inspector found that staff were completing these where required.

The residents PEEPs outlined the supports they required. For example; one resident required verbal instructions and supervision of staff when evacuating the centre. Fire drills had been conducted in each of the three houses to assess whether residents could be evacuated safely from the centre. The records viewed indicated that the residents and staff could be evacuated in a timely manner.

Staff were provided with training/refresher training on fire safety. The registered provider also had systems in place to review fire safety measures. For example; a recent audit recommended that an emergency bag should be in place in each house which should include water and a snack for the residents. The inspector found that this was in place at the time of the inspection.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed the assessment of needs conducted by managers prior to two residents being admitted to the centre and found that a number of improvements were required. For example; a term used in one residents assessment to reflect their assessed need was not accurate and the use of this term could reflect negatively on this resident if this term was not amended. This was discussed with the person in charge and the director of services.

The inspector also met with the director of services to discuss the assessment of need for residents prior to them being admitted to the centre and was assured from speaking to them, that the registered provider was making considerable improvements to address this going forward.

Residents had support plans in place to guide practice in line with their assessed needs and had access to a range of allied health professionals to support some of their assessed needs. For example, in relation to health care, the supports outlined in the plans were in place and staff were aware of those needs.

However, the inspector found that there had been no review of the residents care and support since they had transitioned to the centre by allied health professionals involved in their care. This was important, as since moving to the centre there had been a number of changes in the residents circumstances in relation to behaviours of concern.

Overall, the inspector found that improvements were required to ensure that residents had the supports they required in place prior to being admitted to the centre as identified in their assessment of need. The inspector was assured however that the registered provider was addressing the admission processes in all designated centres at the time of the inspection. Some improvements were required in the review of the residents care.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The inspector found that significant improvements were required in positive behaviour support plans and the interventions included in those support plans to guide staff practice. These support plans were aimed at improving the quality of life of the residents; through the provision of interventions that would guide staff to support residents with their behaviours. They also outlined other interventions such as, communication strategies to assist the residents to communicate their needs in a more positive way. There was also a system to collate information on the residents behaviours which was submitted to behaviour support specialists for review. This information was collated on 'ABC' charts which were used to record in detail what happened before the behaviour incident occurred, what happened during the incident and what happened after the incident.

However, the inspector found that these charts did not provide sufficient detail in some instances and there had been no review of these records or the interventions included in the residents behaviour support plans.

In addition, the details included in these behavioural support plans were not always in practice in the centre. For example; the behaviour support plan for one resident recommended a number of strategies that were not in place. Some of these included; a behaviour contract; a count down timer to assist the resident with waiting for the next task; the introduction of some games to improve communication skills and a separate visual schedules for a resident when they were going on transport. These were not in place. The inspector also found that the behaviour specialist had recommended further training for staff on communication and a sensory assessment for one resident and these had not been completed.

The inspector also found that some of the language used in the behaviour support plan was not easily understood by staff (particularly as the staff had not received training on what these specific terms meant). For example; when the inspector asked a staff member what a specific term meant in the behaviour support plan they did not understand this term.

Some restrictive practices were used in the centre which were all related to environmental restraints like doors or presses being locked. The inspector found that these were in place due to identified risks that could put the resident at risk if those doors were not locked. The reason for these restrictive practices was clearly outlined in the risk assessments for each resident. The inspector was also informed by the person in charge and the team leader that there were no restraints liked physical, mechanical or chemical restraint used in this centre to manage behaviours of concern.

Overall the inspector found that positive behaviour support required review to ensure that residents were receiving consistent effective supports in relation to behaviours of concern.

Notwithstanding, one positive aspect in this centre was that, no restrictive practices were used like physical restraint or mechanical restraint to manage behaviours of concern for residents.

Judgment: Not compliant

Regulation 8: Protection

All staff had completed training in safeguarding vulnerable adults and childrens first training. Staff spoken to were aware of what constituted abuse and the reporting procedures to follow in such an event. There were no safeguarding concerns in this centre at the time of the inspection and the office of the Chief Inspector had not been notified of any such concerns prior to this inspection.

The inspector also found from reviewing records and speaking to staff that the registered provider had clear systems in place to report concerns should they arise in the centre. Some of these assurances were provided through the following observations:

- the two staff members spoken with said they would have no issue reporting a safeguarding concern to management if they had one
- there were no open complaints about the service on file at the time of this inspection
- safeguarding formed part of the standing agenda at staff meetings
- the registered provider had systems in place to audit and review safeguarding in this centre

Overall, this demonstrated that at the time of the inspection residents were being appropriately safeguarded in this centre.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Ardchros OSV-0008723

Inspection ID: MON-0043245

Date of inspection: 01/10/2024

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	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

Talbot Group Medicines Management Working Group continually review medication management practices through a system of comprehensive audits, education, incident identification, reporting and analysis. As part of this continual improvement process the medication Kardex's is undergoing a planned revision, once completed this will ensure full traceability of all transcribers is recorded going forward.

A Senior Member of management will complete a medication management governance oversight audit and any actions will be completed in a timely manner by the Person in Charge in conjunction with the Community Nurse.

A review of all residents Kardex's was completed by the Community Nurse and all kardex's reflect all prescribed medications and all prescribed medications are now signed.

The Medication Management Facilitator presented a group wide lunch and learn education session to all Persons in Charge and Nursing staff on medicines management focusing specifically on medication management passport and the updates to the medication management procedure manual on the 23rd of October 2024.

Actions identified through the monthly medication governance audit will be monitored at governance meetings between the Assistant Director of Services and Person in Charge to ensure all actions are appropriately managed or escalated in the event of non resolution at local level.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The Person in Charge will ensure that arrangements are in place for each resident to access educational and training facilities, supports and services appropriate to their assessed needs and in line with legislative requirements.

To achieve this the Person in Charge will continue to explore school placements in conjunction with the Resident Social worker/HSE representatives and the local special educational needs organisers.

Due to the residents assessed care and support needs, two schools are being identified as appropriate to meet the educational needs of the two residents. The Person in Charge had applied to both schools post admission and no confirmed placements were received. The Residents Social worker visited the Designated Centre on 17th October 2024 and requested for the Person in Charge to re-apply to both schools again and seek a written response.

The Educational Welfare Officer informed the Person in Charge that the admission review meeting for new school placements within the school admission policy occurs between 8th January to the 8th February 2025 so no confirmed placements will be notified till after this time.

The Person in Charge, in the interim, will explore home tuition until such time as a suitable educational placement becomes available that meets the assessed needs of the residents.

The ongoing progress of sourcing an appropriate educational placement will be reviewed monthly at governance meetings between the Person in Charge and the Assistant Director of Services.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
All resident risk assessments were reviewed to ensure all recommendations post incident reviews were reflected in the corresponding risk assessments in place.

The Person in Charge will ensure moving forward post incident review that any controls identified are transferred to the relevant resident risk assessment to mitigate the risk of occurrence.

In addition the Director of Quality and Safety will provide a trending incident report to the MDT team prior to each monthly MDT meeting so that risks in connection with Behaviour Support are being analysed and any outcomes, learning or follow up actions are addressed and outlined in a timely manner.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The Person in Charge ensured that residents were discussed and reviewed at the following scheduled MDT meeting on 18th October 2024. A review of residents' behaviour supports need were addressed and required actions were agreed and minuted which is now placed on file in resident folder. The Person in Charge is currently working through actions with staff team and will update and review with MDT at the next scheduled meeting on the 18th November 2024. All residents are reviewed annually by the MDT, however if residents' needs have changed or new needs present the Person in Charge will request for residents to be reviewed sooner by the MDT.

The Assistant Director of Service and Director of Services provided feedback and learning from this inspection to the policy review team . The assessment process for future admissions has been reviewed to endeavor to ensure that all appropriate information is in place and that all terminology is accurate to assessing the needs of children. There is also a new children specific pre admission assessment currently in development to comprehensively capture all the required information.

The Provider has implemented a post admission audit for the PIC to complete following any future admission to the Centre to ensure all required supports are identified and in place for the resident.

The changes to processes are also reflected in the updated admissions policy, which was disseminated on 01.10.2024.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

The Person in Charge and the Assistant Director of Services met with the Behaviour Support team on the 7th October 2024 and provided feedback and learning from this inspection to the behaviour support team. The behaviour specialists informed the Person in Charge and the Assistant Director of Services that interventions in place were there to be trialed in stage basis. However, the Assistant Director of Services requested that all residents Positive Behaviour Support plans need to be reflective of the current intervention strategies required to manage and support residents behavioural needs. The behaviour specialists agreed to review all Positive Behaviour Support Plans in place in conjunction with the Person in Charge and update to reflect current intervention strategies only.

If the information recorded on the ABC charts was new or demonstrating that behaviours had changed or increased the Person in Charge will request a review from the behaviour support team to ensure that all behaviours are reflected in the resident's Positive Behaviour Support Plan intervention strategies.

The behaviour support specialist met with the staff team on 30th October 2024 to discuss the current strategies included in the residents Positive Behaviour Support Plan and provided a platform for staff to ensure they had received appropriate guidance and training the resident Positive Behaviour Support plans.

In addition the Director of Quality and Safety will provide a trending incident report to the MDT team prior to each monthly MDT meeting so that risks in connection with Behaviour Support are being analysed and any outcomes, learning or follow up actions are addressed and outlined in a timely manner.

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 13(4)(c)	The person in charge shall ensure that when children enter residential services their assessment includes appropriate education attainment targets.	Substantially Compliant	Yellow	15/02/2025
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.	Not Compliant	Orange	30/11/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment,	Substantially Compliant	Yellow	20/10/2024

	management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	18/11/2024
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/10/2024
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	30/11/2024