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:	DC15
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	26 August 2021
Centre ID:	OSV-0005316
Fieldwork ID:	MON-0026246

About the designated centre

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

St John of God Kildare Services DC 15 is a registered designated centre that provides residential care and support for up to seven residents with intellectual disabilities. The designated centre comprises of two community based homes located near each other and situated in community based housing estates outside a large town in County Kildare. Each residential unit that makes up the centre is a modern, spacious home providing residents with their own bedrooms. One residential unit is home to two residents that are provided with one-to-one staffing support and supervision. The second residential unit is home to five residents. A number of residents living in the centre transitioned from a congregated setting operated by St. John of God Kildare Services as part of an overall de-congregation plan for the organisation. Residents living in the centre receive a full-time residential service and are supported by a team of social care workers. A person in charge manages this designated centre and is supported in their role by a social care leader and a senior manager.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 - 2015 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 August 2021	09:30hrs to 17:30hrs	Erin Clarke	Lead
Thursday 26 August 2021	09:30hrs to 17:30hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

The inspectors found that overall, residents were supported to enjoy a good quality of life in which their wellbeing and interests were actively promoted and supported. From meeting and speaking with residents and staff and observing practice, the inspectors found that residents appeared happy and to be enjoying a good standard of care and support. However, in one of the homes, there were compatibility issues that, at times was negatively impacting the lived experience of some residents. The provider had recognised the need for individual supports and had adapted the premises and staffing numbers to help support the residents. However, although these measures were in place, a number of incidents continued to occur. These incidents had the potential to have a significant negative impact on any person living in the home. This is discussed in more detail further in the report.

The designated centre comprises of two homes in close proximity to each other. In the first home, the inspector met with four residents. The residents were in the kitchen and busy getting ready for their day. Two residents were on their way to work and were observed to bring their items and lunches prepared for the day. Residents freely talked about their lives and told the inspector they "loved living in the centre". They spoke about their previous residential placement and the positive differences they observed in their current living arrangements. Residents spoke about staff and family connections. They described busy lives where their person-centred goals were encouraged and developed by the staff team. For example, one resident told the inspector about how they were learning to cook. Their keyworker later described how they were creating a cookery book together. Holidays were planned and facilitated, and residents were excited about upcoming holidays in the coming weeks.

Residents spoke about the impact of Covid-19 restrictions on their lives and what they missed most. They understood the importance of washing hands and the wearing of face coverings on public transport. The person in charge and social care leader had put programs in place to help the residents cope with the restrictions, such as a wish jar of activities to be completed when restrictions were lifted. A number of these activities had been completed, such as eating out in restaurants and visiting places of interest.

The first home had a warm and pleasant atmosphere. The residents' communal areas were decorated in a homely manner and contained games and activities in line with residents' individual preferences. Residents had access to all areas of their home, and they were relaxed and casually chatted with staff on duty. Residents were observed to come and look for staff when they needed help. Staff responded immediately to any requests by residents. Staff were observed and overheard being respectful and courteous to the residents over the course of the inspection, and residents appeared relaxed in their company. Residents were very familiar with the staff on duty and introduced them to the inspectors. Staff were also observed to be familiar with residents' assessed needs and were seen to support residents

appropriately and in a very caring manner.

Another resident greeted the inspector and asked if they could have a conversation in the sitting room. They told the inspector they were returning to their day service after a long break due to the COVID-19 pandemic, which they were looking forward to. They also excitedly informed the inspector of their plans to celebrate a big birthday. After that, residents went about their normal day and routines, and the inspectors used this time to review documentation relating to the centre overall and individual residents. One such document reviewed was the most recent annual review conducted for the centre. This contained feedback from residents, family members and staff; it was noted in the annual review that the feedback from all stakeholders was very positive, with no concerns listed. As part of the inspection announcement, questionnaires from the inspectorate were sent to the designated centre for residents and families to fill in. These questionnaires aimed to give residents an opportunity to provide feedback on what it is like to live in the centre. One questionnaire was returned to the inspectors by some residents who wanted to complete the questions collectively. These residents indicated they were happy with their service, happy with the choices available to them, and how their rights were respected.

Residents were encouraged and supported around active decision making and social inclusion. Residents meetings called "Speak Up" were held regularly in both houses of this designated centre. In line with the centre's statement of purpose, such meetings were to be used to discuss issues of relevance to residents such as staffing, meals, activities and how to make a complaint. The inspectors reviewed the minutes of such meetings and noted that the meetings were being used in this way. The minutes of these meetings showed that residents participated in the house's organisation and were informed of any developments or changes. For example, information was shared regarding the easing of restrictions and the rollout of the vaccine programme. Residents also discussed the payment of bills as part of shared living and the importance of showing respect to their peers.

In the second home, the inspector met with one resident and their supporting staff. One other resident was on a long-awaited holiday abroad to visit relatives. The inspector observed that residents appeared to enjoy high levels of staff support in this house, with all residents supported one to one by staff throughout the day. The house had a garden to the rear, and one part of the garden was developed into a wildflower garden. A staff member informed the inspector one of the residents was interested in gardening and had created this area as part of their identified goals.

The resident showed the inspector their bedroom and separate living room on the third floor and items of interest, including a vast CD collection. The resident played some music and appeared to enjoy this and the interaction they received from the staff present. The inspector noted that some improvements were required to the fire precautions on this floor as a fire door was wedged open. The resident told the inspector they were due to go out on public transport with staff, and it was evident that they were looking forward to going out on this activity.

From meeting with the residents, the feedback received informed the inspectors that

ensuring residents felt secure in their environment was a priority; residents like that the staff are familiar to them and know how to support their needs. The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the residents' lives.

Capacity and capability

This announced inspection was announced to the provider and the person in charge on 26 July 2021 to gain further information in relation to the centre's application for renewal of registration. Furthermore, unsolicited information was received by the inspectorate the day before the inspection concerning the compatibility of some residents and the impact of these residents living together. Overall, the inspectors found that the management arrangements were striving to promote residents' welfare, wellbeing, and safety, and the provider had taken action in response to the previous inspection findings in September 2020. The inspectors reviewed incident records, safeguarding plans and personal plans of the residents forementioned and found substantiating evidence that corroborated with some of the unsolicited information. This is mentioned further in the report under 'Quality and Safety'. Improvements were also required regarding the timely submission of notifications to the Chief Inspector and the monitoring systems in place to ensure that the services provided in all three houses were consistent.

The centre had last been inspected in September 2020; however, due to COVID-19 restrictions, the inspector only visited one of the two houses to reduce crossover between the two houses. During this inspection, improvement was identified with regards to one evacuation route in the centre. The provider was required to have a person appropriately qualified in fire safety review the evacuation route and, on foot of this review, make arrangements to address any recommendations made in a timely way. The provider had implemented the recommendations to ensure the safe evacuation route of one resident, and the provider had confirmed the works were completed in February 2021 to the Chief Inspector.

There was a clearly defined governance and management structure in place. The centre was managed by a full-time person in charge, the residential cooridinator, who was appropriately qualified and experienced and demonstrated good knowledge of the residents and their assessed needs. The person in charge was also responsible for the management of another designated centre and the line manager for another person in charge. They were supported by a social care leader who worked supernumerary to the staffing roster. The inspectors were informed that the social care leader was in the process of being appointed person in charge post inspection as they were based in the centre and could provide increased oversight of the day to day operations of the centre. The inspectors noted that improvement was required to the person in charge oversight of the centre as documentation and meeting minutes reviewed by the inspectors showed the person in charge did not

complete these.

In keeping with the requirements of the regulations, the provider had systems in place to monitor the quality and safety of care and support provided. These included carrying out unannounced provider visits at six-monthly intervals, with such visits reflected in written reports. An accessible version of the annual review was also provided to residents. In addition, regular meetings were held with other persons in charge within the service. These were used as a platform for shared learning and discussion regarding the service and ongoing issues, such as COVID-19 and operational changes.

It was found that there was sufficient staff with the necessary experience to meet the needs of the residents living in the service. There was good evidence of continuity of care with the service identifying that a stable staff complement was essential to support residents with specific assessed needs. The staff on duty on the day of inspection were pleasant, and they interacted with the residents in a warm and friendly manner. Residents were familiar with the staff team and were very comfortable in their presence. Staffing arrangements were in place to ensure residents were safeguarded; despite this control measure being in place, a number of significant incidents were still occurring, which potentially impacted the lived experience of residents. This is discussed in more detail in regulation 8 Protection.

The inspectors found that, for the most part, the education and training provided to staff enabled them to provide care that reflected up-to-date, evidence-based practice. The training needs of staff were regularly monitored and addressed to ensure the delivery of good quality, safe and effective services for the residents. The inspectors found that staff had been provided with mandatory training such as fire safety, manual handling and safeguarding. Due to the difficulty in facilitating internal and external trainers during the COVID-19 pandemic, the provider had redeveloped some training so it could be delivered online to staff. The inspectors did observe that some improvements were needed to ensure all staff received refresher training in dysphagia in line with residents' assessed needs.

The inspectors reviewed a sample of incident, accident and near-miss records maintained in the centre. Two incidents of a safeguarding nature had been notified to the Chief Inspector in 2020 and 2021 for residents from one house. Submitting such notifications is required under regulations and is essential so that the Chief Inspector is aware of events that can negatively impact the residents living in a designated centre. However, on reviewing the incident log for 2021, the inspectors identified 11 other incidents involving the same residents that impacted their emotional and physical wellbeing that were not notified. In addition, other required notifications had not been submitted as discussed under regulation 31 Notification of Incidents.

The inspectors completed a review of the arrangements for the management of complaints and found that the registered provider had established and implemented an effective complaints management system. There was a system in place for staff to raise concerns, both in staff meetings and by addressing concerns directly with the person in charge should the need arise. There was a complaints policy in place,

and there were easy read complaints procedures on display.
Complaints reviewed were treated in a serious and timely manner. The centre's management team had escalated concerns where they could not be resolved at a local level, and steps taken had been documented.

Regulation 14: Persons in charge

A suitably qualified, skilled and experienced person in charge was in place for this designated centre.

The inspectors found that the person in charge's current governance remit did not always ensure the effective governance, operational management and administration of the designated centre at all times. This is addressed under regulation 23 Governance and management.

Judgment: Compliant

Regulation 15: Staffing

As previously discussed, maintaining a consistent roster and having familiar staff were essential to residents and their wellbeing. This was an important requirement in one house in particular. Due consideration was found to be given by the provider to ensure that the centre recruited staff that could effectively support the residents' specific needs. Residents were supported by a staff team who were familiar with their care and support needs.

The inspector found that there were arrangements in place for continuity of staffing so that support and maintenance of relationships were promoted. A core team of staff were employed in this centre, and where relief staff were required, the same relief staff who were familiar to the residents were employed.

There was one whole-time equivalent social care worker vacancy in one house, but this was due to be filled the following week. Also, in another house, the use of agency staff had resumed since the restrictions by the provider to reduce footfall to the centre had eased. However, the inspectors were informed this was to cover annual leave and were completed by the same person.

Judgment: Compliant

Regulation 16: Training and staff development

Staff received mandatory training such as safeguarding vulnerable adults, safe administration of medicines, and fire training. The records reviewed indicated that all staff had completed this training.

Staff who spoke with the inspectors demonstrated a good understanding of the resident's needs and were knowledgeable of the procedures related to the general welfare and protection of residents. For the most part, staff had access to and completed training and refresher training in line with residents' assessed needs. However, not all staff had completed training concerning feeding, drinking, and swallowing requirements.

There was a supervision plan to ensure all staff had access to formal supervision to support them in carrying out their roles and responsibilities to the best of their abilities. Regular one-to-one supervision meetings were taking place with all staff members that included skills building. Staff spoken with said they felt supported by management and comfortable to raise any concerns they may have. However, the inspectors identified that improvements were required in relation to the frequency of staff meetings. These meetings reviewed matters relating to residents' care and support, health and safety issues, safeguarding and reviewing of incidents. The inspectors reviewed the staff meetings for one house and found long gaps between meetings. A meeting was held in November 2019, and the next meeting was in July 2020 and then not until April 2021. The inspectors acknowledged that face to face meetings were difficult during the pandemic. However, taking into account the challenging working environment for staff, the complex needs of residents in this house and the person in charge not being based at the location, these systems required review to ensure staff were being met with by management on a regular basis.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was evidence that the service provided was regularly audited and reviewed. An annual review and a six-monthly audit on behalf of the provider had taken place. The inspectors found that the social care leader and staff carried out a schedule of local audits throughout the year, including audits relating to the care and support provided to the residents living in the centre. These included personal care plans, financial audits, medicines and fire precautions. However, the inspectors found that the review and oversight of documentation in the centre required improvements. For example, the systems in place to review residents' behavioural support plans did not adequately assess the effectiveness of the strategies, and the monitoring of peer-to-peer incidents at times appeared limited. Incident report reviews were not completed by the person in charge or senior management, which resulted in missed allegations of abuse, opportunities for learning and implementation of adequate corrective actions.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Although some incidents had been reported to the Office of the Chief Inspector in line with the requirements of the regulations, a number of incidents were not reported. For example, the requirement of notifying the Chief Inspector of any incidents of any incidents of staff misconduct was not completed in line with the relevant regulation.

Judgment: Not compliant

Regulation 34: Complaints procedure

There was a self advocacy group within the organisation and a complaints policy and procedure in place to support residents and their families raise any issues the may have in relation to the service provided. There was a robust complaints policy in place in the centre however, there were no complaints logged for 2021. From a review of complaints inspectors found that all documents included the issue, the complainant, date and time the complaint was made, who the complaint was made to, the outcome and the complainants satisfaction or otherwise.

There were no complaints communicated with the inspectors on the day of inspection either in person or through questionnaires sent to the centre in advance of the inspection for residents and families to fill out regarding their views of the service provided.

Judgment: Compliant

Quality and safety

The provider and person in charge were striving to ensure that residents were in receipt of good quality and safe service. The residents lived in clean, warm and comfortable homes. Most residents had lived in the centre for a number of years and appeared happy and content in their homes. Some residents told the inspectors how much they enjoyed living in their homes and that they were well cared for. However, a number of incidents were occurring in one of the homes in the designated centre. These incidents, at times, were negatively impacting the residents' overall lived experience.

As previously discussed, improvements were required with the positive behaviour support systems in place in the centre. There were guidelines on supporting persons with behaviours of concern. However, they had not always been reviewed by a suitably qualified person. There was limited evidence of multi-disciplinary input and review of residents' positive behaviour support plans. In addition, incidents were not being reviewed in line with evidence-based practice. Incident tracking and analysis were not always being used to indicate if the behaviour support strategies were effective.

The inspectors reviewed a sample of residents' files and personal plans. It was found that residents were central to their personal planning process and that their will and preference were respected with regards to decision making. Residents were supported to set and achieve personal goals in order to enhance their quality of life. Residents spoken with were satisfied that they could engage in hobbies of their choosing, and that they could make decisions about how they spent their time. Some improvements were required to the assessment of need planning tool to ensure it included a holistic view of the residents' needs and expanded upon the captured healthcare needs.

Appropriate healthcare was made available to residents having regard to their personal plan. Plans were regularly reviewed in line with the residents assessed needs and required supports. The health and wellbeing of each resident was promoted and supported in a variety of ways including through diet, nutrition, recreation, exercise and physical activities. From reviewing a sample of residents' health management plans and recent consultations with allied health professionals, it was evident that residents' changing needs were being closely monitored and supported. Further consultations with the relevant allied health professionals were being arranged promptly. The person in charge was sourcing additional information relating to one resident and emerging healthcare needs and linking with the appropriate health professionals to support them in line with their assessed needs. Residents' plans also demonstrated many physical activities residents were supported to engage in when community activities were limited due to COVID-19 restrictions. Residents were also encouraged to take part in online physical exercise and keep fit programmes.

There were usage of PRN (as required) medicines administered to manage residents' anxiety and other mental health difficulties. In some documented cases, the inspectors found that anxiety medicines were administered to residents whose anxiety was triggered by other residents' behaviour. The inspectors found that other alternatives could not always be considered in managing these behaviours due to the living arrangements of the residents and the presence of ongoing triggers.

During the inspection the premises was found to be clean. There were cleaning schedules in place, which had been adapted in line with COVID-19. Information was available for residents and staff in relation to COVID-19 and infection prevention and control. The provider had developed policies, procedures relating to infection prevention and control. They had also developed contingency plans for use during the pandemic. Some of these documents had not been updated since May 2020, and some information was not pertinent to the current situation. For example, the

COVID-19 response plan (dated May 2020) stated that agency staff were to be phased out by May 2020. The designated centre had utilised agency staff in recent weeks as this control measure was no longer needed. In addition to this, although there were adequate hand basins and soaps, one bathroom had no paper towels in place throughout the day of inspection.

Residents were supported to manage their own financial affairs and financial assessments were completed to determine the level of support required to match the level of dependence. From a review of files, residents were supported to manage and access their finances, paid into bank accounts in the residents' name. Each resident had their own bedroom which they could lock if they wished. Staff in the centre also maintained a log of each resident's personal possessions for safeguarding.

Regulation 12: Personal possessions

All residents had their own bank account. Each resident had a financial assessment carried out and a care plan to ensure that residents were supported to be as independent as possible with their finances while ensuring they were appropriately safeguarded. The person in charge informed the inspectors that the residents' financial records were currently under audit by the finance department to ensure expenditure aligned with organisational policy.

From meeting with residents and viewing all of the bedrooms in the centre, it was evident that residents were supported to have control over all of their personal possessions, with adequate space to store clothes and other personal effects. Residents rooms were decorated in line with their preferences and had items such as televisions, photographs, medals and a range of other possessions personal to each resident. In addition, documentation reviewed showed a personal inventory of possessions was kept for each resident to ensure personal effects were secure and protected.

Judgment: Compliant

Regulation 13: General welfare and development

The residents were actively supported and encouraged to experience a full range of activities and relationships with friends and family. Although the Covid-19 restrictions had impacted the residents' ability to access their community, the staff made a considerable effort to ensure residents had a range of activities and strategies to utilise during this time. For example, residents had access to different types of technology and were taught the skills to communicate independently with friends and family. Residents were planning a range of activities to complete now

that restrictions were easing and readily told the inspectors about their upcoming plans such as holidays and family visits.

Judgment: Compliant

Regulation 17: Premises

Both properties in the designated centre were well maintained and clean both internally and externally. Throughout the premises, efforts had been made to make the centre homelike with plenty of residents' photographs while the premises were also well furnished. The inspectors also saw some residents' bedrooms, which were personalised and had sufficient storage for residents' personal belongings.
Additional funding had been applied for through the fundraising committee to renovate and convert a spare room in one of the houses into a sensory room. This was recently successful, and the inspectors viewed the proposal for the changes, including a light projector.

Judgment: Compliant

Regulation 27: Protection against infection

For the most part, residents were protected by the policies, procedures, and practices relating to infection prevention and control in the centre. The centre was visibly clean on arrival, and enhanced cleaning schedules had been implemented. All staff were observed wearing face masks. Management and staff were adhering to national guidelines for the management of COVID-19 in residential care facilities. However, some improvements were required.
The provider had developed a contingency plan in response to the recent COVID-19 pandemic; however, the inspectors found the measures outlined in this plan were not reflective of the practices observed as the plan had not been updated since May 2020. In addition, the COVID-19 self-assessment tool developed by the Chief Inspector to aid providers to critically assess their preparedness, contingency and outbreak management plans to assure themselves that the infection prevention and control practices in their centres are safe was not updated every 12 weeks as required.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The inspectors observed fire safety measures located all around the designated centre including detection systems, emergency lights, alarms, fire fighting equipment and signage. A fire specialist attended the centre regularly to service these.

All residents had personal emergency evacuation plans in place and evacuation procedures were prominently displayed in the centre. Staff were completing regular fire evacuation drills and completing visual fire safety checks on a daily and weekly basis.

Two fire doors were not functioning effectively in a high risk areas on the day of inspection and this impacted the efficiency of the containment measures in the centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents were supported to make choices and decisions with regard to activities and personal goals. There was a key working system in place, and key workers supported residents to achieve set personal social goals in place, which were agreed upon at residents' personal planning meetings. The inspectors viewed a sample of person centred plans. There was photographic evidence of the activities which residents had enjoyed during the pandemic and the plans were audited to ensure goals continued to progress for residents.

Although the provider had carried out various assessments in relation to residents needs, including an annual health action plan, there was no comprehensive assessment of need as required by regulations that included the social and personal needs of the resident to ensure that the centre could meet the residents' needs.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were supported to have the best possible health with plans of care developed to support the assessed needs in relation to health matters. Residents were also facilitated to engage in national health screening programmes.

All residents had full health screening checks completed annually and relevant referrals were made to multi-disciplinary supports when required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Although the provider had made considerable efforts to ensure the residents were supported appropriately, including a medical review due to emerging healthcare needs, there remained the presence of ongoing triggers that impacted the strategies' effectiveness. Also, despite an increase in behaviours of concern in 2021, the last documented review by an appropriate multi-disciplinary team member was November 2020. As a result, evidence-based practices were not utilised to inform the effectiveness of positive behaviour support plans.

Judgment: Not compliant

Regulation 8: Protection

The inspectors found not all incidents of a safeguarding nature had been managed and reported in line with organisational and national policy. On reviewing the incident log, inspectors identified numerous incidents that caused harm to another resident where staff had captured the adverse impact for residents. These included a resident being "anxious when another resident was shouting at them", "verbally abusive", and also "threatening physical violence". Some incidents of a physical nature also had not been notified or managed through the organisation's established mechanisms.

In addition, where safeguarding plans were in place, it was not evident that they were fully effective as a number of similar incidents continued to be reported by staff. The inspectors were particularly concerned where incidents occurred outside of one-to-one staffing support hours or where non-care staff had to intervene for staff safety, which did not result in clearly identified learning outcomes and actions to keep residents and staff members safe in the centre. The review of these incidents were inadequate and repetitive of similar incidents informing staff to utilise one-to-one supports and follow the behavioural support plan.

Judgment: Not 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 - 2015 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	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for DC15 OSV-0005316

Inspection ID: MON-0026246

Date of inspection: 26/08/2021

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Dysphagia training for staff that required same has been scheduled and Staff will have this completed by the 30/11/2021 • Autism specific has been scheduled for staff in one area and will be completed on the 31/10/2021 • Additional training in report writing has been scheduled for staff in one area and will be completed by 31/10/2021 • The Person In Charge and Social Care Leader will monitor the effectiveness of the implementation of the training through both individual supervisions and in staff meetings going forward	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Person in Charge and the Social Care Leader have reviewed all documentation to ensure all residents' plans are adhered to and that all incidents are reported appropriately. Completed and is on-going Staff meetings are now held every two weeks, and will included a team review of all Behaviour Incidents and safeguarding notifications. This will ensure that shared learning about the event are identified and acted on. The reviews will also identify any areas where behavioural support plans are ineffective and require changes. 10/09/2021	

Roster change has been introduced; one house has changed to a waking night in order to better support resident's needs. 20/09/2021

Daily email reports have now been implemented to enhance oversight: night time and day reports are forwarded to all team members, and the Social Care Leader & Person in Charge. These reflect the resident's meaningful day activities, appointments with healthcare practitioners & any incidents/events that have arisen. This allows for immediate responses from managers to support staff in ensuring all parts of their plans are being implemented. 05/09/2021 and ongoing

Management meetings have been introduced monthly between the Social Care Leader, Person in Charge, Programme Manager and the Social Work representative (if required), to review the effectiveness of the care and support being provided and identify any opportunities for learning and where additional supports would be required. 30/09/2021 and ongoing.

Management presence in the Designated Centre is at a minimum of 6/7 days to ensure staff are supported and that the interactions and wellbeing of residents are monitored. Managers ensure that meaningful day activities are implemented for residents and are positive and meeting their needs. 06/09/2021 and ongoing

The Social care leader will maintain records of management oversight and interventions in the centre.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PIC/SCL will review all incidents reported to them as they are reported during the daily reports and undertake the necessary notifications to the DO and/or the Authority.

The SCL or PIC will review residents files weekly to ensure all incidents that require notification are captured.

In the PIC's absence the PPIM will undertake the notifications.

All incidents which require notification will be completed within the appropriate timeframes.

06/09/2021 and ongoing

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The most up to date Regional Covid Contingency Plan has been issued in the designated centre and is implemented and being followed. 16/09/2021

Covid 19 Self Assessment tool to aid providers to critically assess preparedness, contingency & outbreak management plans has been updated and will be reviewed quarterly 30/09/2021

The Liffey Region is currently drawing up a number of actions to support Persons in Charge and ensure designated centres can achieve compliance with forthcoming Regulation 27 inspections. 31/10/2021

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Two new fire doors have been installed in the Designated Centre 09/10/2021

Automatic Closures will be fitted to doors that require same due to resident's preference for doors to remain open. 30/11/2021

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 MPP file is made up of a number of individual assessments completed prior to the admission (e.g. Health Care Assessment, All about me, Communication plan, Manual Handling Assessments, Eating and Drinking Assessments etc.) which as a whole make up the assessment of need. The residents' needs are met as a result of the completed assessments and subsequent care and personal plans that are put in place to meet the needs identified in assessments.
The Liffey Region management team reviewed the current documents and process and

agreed to put in place a signposting system to link all aspects of the MPP and where necessary collate copies of individual parts of the assessments to improve ease of access. This is being rolled out incrementally and will be in place by 16/01/2022.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Specific training, supports and ongoing reflection of how to meet complex needs effectively has been made a specific priority for the centre and the team, and these activities underpin the enhanced oversight provided in the designated centre.24/09/2021 and ongoing.

A MDT meeting was held in August 2021 in relation to the identified changing needs within one house and actions were identified to address current and future needs.

A referral was made to both the Admission, discharge and transfer committee and to the changing needs committee so that future needs can be proactively supported.

A second referral was made in August 2021 for a psychology review of the Behaviour Support Plans for both residents to ensure all proactive and reactive strategies are captured and effective. This is being followed up by the PPIM. 31/10/2021

One resident was reviewed by their medical Consultant in August 2021. The treatment was reviewed and reconfigured as it was felt that the treatment plan may be impacting adversely on the individual. The revised treatment has had a very positive impact as was suspected. 19/08/2021.The revised treatment plan was then reviewed again by the clinician concerned after 6 weeks (30/09/2021) and the plan is being maintained going forward because of its effectiveness.

A resident has been reviewed by Senior Psychiatrist Registrar and treatment for anxiety has been discontinued as it is no longer required following the interventions already described.

The Social Care Leader and the Person in Charge assessed and reviewed the circumstances, frequency and types of incidents in one part of the designated centre. The review clearly identified a pattern which indicated there were inadequate supports and planning in place prior to and during some incidents. As a result, clear and precise protocols have been put in place for the residents concerned on a daily basis. These ensure transitions and daily planners reflect the individualized supports and facilities they need to help manage those parts of the day positively and with positive outcomes. Completed and ongoing

Increased communication between staff and managers has been put in place to ensure daily activities, transitions and protocols are adhered too in the form of managers presence, staff meetings, staff supervision and daily reporting between the team. Completed and ongoing

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Risk assessments are now being reviewed in relation to residents peer on peer abuse/interactions on a two weekly basis by the SCL and PIC. Any increases in risk are discussed and controls identified and implemented. 06/09/2021 and ongoing.

The risk rating will also be reviewed at the monthly management meetings with the PPIM. 7/10/2021 and ongoing.

Safeguarding incidents have been forwarded to the designated officer for screening and then submitted to CHO7 safeguarding team. Those submitted were closed. 08/10/2021

The PIC analysis of previous potential safeguarding incidents in one area have identified inconsistencies in following expected routines and some non-adherence to daily plans and behaviour support plans which led to negative interactions between residents. The Person in Charge and Social Care Leader reviewed and discussed these incidents with the staff team during team meetings, to ensure shared learning for all staff. All incidents will be reviewed in a timely way going forward by managers and at team meetings, and any difficulties or inconsistencies will be addressed. 20/09/2021 and ongoing

The Social Care Leader and Person In Charge continue to support staff to reflect on incidents, and have implemented significantly increased oversight locally and within the residential management team. This will be achieved through team meetings, daily reporting, unannounced checks, incident review, management meeting for the centre and team meetings, increased training and supervision. This will highlight areas where staff have implemented effective best practice that can results in positive outcomes for residents and identify where practice and planning needs to improve. 06/09/2021 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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/11/2021
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	30/09/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare	Substantially Compliant	Yellow	31/10/2021

	associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/11/2021
Regulation 31(1)(g)	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 of misconduct by the registered provider or by staff.	Not Compliant	Orange	01/09/2021
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	Not Compliant	Orange	01/09/2021

	to a resident not required to be notified under paragraph (1)(d).			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	16/01/2022
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	30/11/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/10/2021
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any	Not Compliant	Orange	01/09/2021

	incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.			