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

Issued by the Chief Inspector

Name of designated centre:	Ballymun Road
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Announced
Date of inspection:	04 December 2024
Centre ID:	OSV-0002379
Fieldwork ID:	MON-0036980

About the designated centre

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

Ballymun Road is a designated centre operated by Saint Michael's House located in North County Dublin. It provides a community residential service to six adults with intellectual and physical disabilities. Each person has their own bedroom. There is a communal kitchen /dining room and a separate shared sitting room area. There is a large enclosed back garden with patio and garden furniture. The centre is staffed by the person in charge and social care workers. Ballymun Road aims to provide a homely environment where individuals are supported to live as independently as possible and make choices about their lives.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Wednesday 4 December 2024	09:45hrs to 17:30hrs	Karen McLaughlin	Lead

What residents told us and what inspectors observed

This report outlines the findings of an announced inspection of the designated centre, Ballymun Road. The inspection was carried out in response to the provider's application to renew the registration of the designated centre.

Conversations with staff, observations of the quality of care, a walk-around of the premises and a review of documentation were used to inform judgments on the implementation of the national standards in this centre.

The centre comprised of a large two-storey house located in North Dublin. The centre was located close to many services and amenities, which were within walking distance and good access to public transport links. The centre was registered to accommodate six residents.

Overall, the inspector found the centre to be clean, bright, homely, nicely-furnished, and laid out to the needs of residents living there. Each resident had their own bedroom. All the bedrooms were personalised to the residents' tastes with art-work, photos of family and of residents attending events and activities on display. Three residents showed the inspector their respective bedrooms.There was sufficient storage facilities for their personal belongings in each room. The house had recently been decorated for Christmas in preparation for the residents' Christmas party. There was also a number of shared bathrooms, a staff office and a nice garden space for residents to use, which had recently been upgraded into a sensory garden. One resident said they would like a Seomra style structure out the back so that they could have friends visit.

The person in charge described the quality and safety of the service provided in the centre as being very personalised to the residents' individual needs and wishes. They spoke about the high standard of care all residents receive. In addition, they spoke about the challenges in relation to compatibility issues which were ongoing in the centre.

Staff highlighted concerns about some of the residents' changing and increased needs, and on the compatibility of residents which they felt created a busy and pressurised work environment that could impinge on the quality of service provided to residents. The provider and the person in charge were responding to the residents' changing needs and mixed compatibility by increasing staffing levels and supporting residents through their personal and behaviour support plans.

The inspector observed residents coming and going from their home during the day, attending day services and making plans for the evening. Throughout the inspection, residents were seen to be at ease and comfortable in the company of staff. It was clear during the inspection that there was a good rapport between residents and staff. The inspector saw that staff and residents' communications were familiar and kind. Staff were observed to be responsive to residents’ requests and

assisted residents in a respectful manner.

Residents were being supported to partake in a variety of different leisure, occupational, and recreation activities in accordance with their interests, wishes and personal preferences. For example, when the inspector asked staff what activities do residents enjoy participating in, they were told that residents enjoy yoga, tai chi, drama, music, social outings, reflexology and trips away. Most of the residents in the house had busy social lives outside of the centre and attended local clubs as well as accessing the library, the park and other amenities in the area. For example, on the day of the inspection three of the residents had plans in the evening to attend two separate parties. One resident showed the inspector their outfit and talked about their socialising plans for the next few weeks in the lead up to Christmas.

All residents were aware of the inspection visit. In advance of the inspection, residents had been sent Health Information and Quality Authority (HIQA) surveys. These surveys sought information and residents' feedback about what it was like to live in this designated centre. All six of the surveys were returned to the inspector.The feedback in general was very positive, and indicated satisfaction with the service provided to them in the centre, including the premises, meals, and care provider, however the majority of the surveys noted that residents did not feel safe in their home and this was impacting on their quality of life.

The inspector met with and spoke to three residents on the day of the inspection. Residents said that they were happy with the service. They told the inspector they liked their bedrooms and the layout and décor of their home. One resident spoke about things they liked to do and showed the inspector some photo albums they had made of their activities.

Two residents spoke to the inspector about the impact the compatibility issues were having on their quality of life. One resident told the inspector that another resident didn't get along with the other residents and staff supported by saying this was the result of this residents changing needs. However, the resident also said they liked living in their home and enjoyed going on holidays and doing activities with staff. The other resident said that one of the other residents can be very noisy especially at night. Both of these residents told the inspector they stayed in their bedrooms to avoid conflict with another resident who 'took over' the sitting room and kitchen area of the house. One said they would like more space so that their friends could visit in private.

The inspector did not have an opportunity to meet with any of the residents family members or representatives however, they did speak on the phone to one resident's sibling who said they 'couldn't fault the care provided, that staff go above and beyond and are doing all they can'. They also informed the inspector they were concerned with the impact compatibility issues were having on their sibling, saying that 'they cant articulate that their upset but I know it gets to them, they are very quiet and withdrawn now and shows a reluctance to return back to the house now'.

From what the inspector observed, read, and was told, it was clear that the residents, for the most part, had active and rich lives. The residents were

encouraged and supported to live independent lives in line with their will and preference. However, this inspection found there were improvements required in relation to Regulation 5: Individualised assessment and personal plan, Regulation 8: Protection and Regulation 9: Residents' rights. This is further discussed in the main body of the report.

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

Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations and, to contribute to the decision-making process for the renewal of the centre's registration. This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

The management structure in the centre was clearly defined with associated responsibilities and lines of authority. The person in charge was full-time and supported in the management of the centre by a service manager. The person in charge reported to a service manager and Director, and there were effective systems for the management team to communicate and escalate any issues.

The registered provider had implemented management systems to monitor the quality and safety of service provided to residents including annual reviews and six-monthly reports, plus a suite of audits had been carried out in the centre.

From a review of the rosters there were sufficient staff with the required skills and experience to meet the assessed needs of residents available.

There were supervision arrangements in place for staff. In addition, staff completed relevant training as part of their professional development and to support them in their delivery of appropriate care and support to residents.

Records set out in the schedules of the regulations were made available to the inspectors on the day of inspection. When reviewed by the inspector these were found to be accurate and up to date including an accurate and current directory of residents, residents guide and complaints log.

Furthermore, an up-to-date statement of purpose was in place which met the requirements of the regulations and accurately described the services provided in the designated centre at this time.

This inspection found that systems and arrangements were in place to ensure that residents received care and support that was person-centred and of good quality.

However, improvements were required in relation to safeguarding and residents rights.

Regulation 15: Staffing

The staffing arrangements in the centre, including staffing levels, skill mix and qualifications, were effective in meeting residents' assessed needs.

There was a planned and actual roster maintained by the person in charge. The inspector reviewed actual and planned rosters at the centre for November and December 2024.

The inspector observed staff engaging with residents in a respectful and warm manner, and it was clear that they had a good rapport and understanding of the residents' needs.

The registered provider had ensured that they had obtained, in respect of all staff, the information and documents specified on Schedule 2 of the Health Act 2007. A sample of which had been requested by the inspector who reviewed two staff records on the day of the inspection and found them to be accurate and in order.

Judgment: Compliant

Regulation 16: Training and staff development

There were mechanisms in place to monitor staff training needs and to ensure that adequate training levels were maintained. Refresher training was available as required.

All staff were up to date in training in required areas such as safeguarding vulnerable adults, infection prevention and control, manual handling and fire safety. Furthermore staff were in receipt of risk assessment training and positive behaviour support.

Staff had also completed human rights training to further promote the delivery of a human rights-based service in the centre.

Staff were in receipt of regular support and supervision through monthly staff meetings and quarterly supervisions with the person in charge. Records of these meetings were maintained by the person in charge.

Judgment: Compliant

Regulation 19: Directory of residents

A current and up-to-date directory of residents was available in the designated centre and included all the required information specified in Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

The registered provider had ensured the records of information and documents pertaining to staff members as specified in Schedule 2 was correct and in order.

Similarly, the sample of records viewed pertaining to Schedule 3 and 4 were correct and in order and were made available to the inspector upon request including the designated centre's statement of purpose, residents' guide, fire safety log (including a record of drills and the testing of equipment) and a record of all complaints made by residents or their representatives or staff concerning the operation of the centre.

Judgment: Compliant

Regulation 22: Insurance

The provider submitted a copy of their insurance along with their application to renew the centre's certificate of registration. The inspector saw that the provider had in place a contract of insurance against injury to residents and damage to the premises of the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined governance structure which identified the lines of authority and accountability within the centre and ensured the delivery of good quality care and support that was routinely monitored and evaluated.

There was suitable local oversight and the centre was sufficiently resourced. For example, there was sufficient staff available to meet the needs of residents, adequate premises, facilities and supplies and residents had access to a transport vehicle which was assigned for the centre's use only.

The provider had carried out an annual review of the quality and safety of the centre, and there were arrangements for unannounced visits to be carried out on the provider's behalf on a six-monthly basis. Residents, staff and family members were all consulted in the annual review. Residents said they were happy in their home and staff know them well, however they would like to spend more time in the sitting room but this can be difficult due to the needs of another resident. Family members commented that the 'centre is a real home' and another said their loved one is very happy. Families consulted with expressed concerns about the compatibility of residents, with some making formal complaints. While the complaints procedure was followed, due to the nature of the complaints and the ongoing compatibility issues in the centre these complaints remained unresolved and are currently under review with the providers Director of Quality and Risk.

Other audits carried out included fire safety, infection prevention and control (IPC), medication management audits and regular safeguarding audits/tracking due to the increasing amount of safeguarding concerns in the designated centre.

There were good arrangements in place such as regular meetings for the management team to communicate and escalate issues. Safeguarding concerns were well documented and due to the complex nature of the compatibility issues ongoing multi-disciplinary meetings, increased staffing and advocacy supports had been introduced to reduce impact on the residents.

The inspector reviewed the last two team meeting minutes from October and November 2024. The November meeting minutes provided an update on safeguarding concerns and the most recent compatibility review on the 19th October 2024, which had identified one residents need for an individualised service, this is discussed further under Regulation 5: Individualised assessment and personal plan.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed on inspection and was found to meet the requirements of the Regulations and Schedule 1 and clearly set out the services provided in the centre and the governance and staffing arrangements.

A copy was readily available to the inspector on the day of inspection.

It was also available to residents and their representatives.

Judgment: Compliant

Quality and safety

This section of the report details the quality and safety of service for the residents who lived in the designated centre.

This inspection found that the provider and person in charge were operating the centre in a manner that supported residents to receive a service that was person-centred. However, as previously stated improvements were required in relation to residents rights and safeguarding.

The design and layout of the premises ensured that each resident could enjoy living in an accessible, comfortable and homely environment. The provider ensured that the premises, both internally and externally, was of sound construction and kept in good repair. There was adequate private and communal spaces, however access to the communal areas were restricted due to the behaviour of one resident. As a result of this other residents were choosing to spend time in their bedrooms as opposed to the communal living areas because they feel unsafe.

There were appropriate fire safety measures in place, including fire and smoke detection systems and fire fighting equipment. The fire panel was addressable and there was guidance displayed beside it on the different fire zones in the centre. The inspector observed the fire doors to close properly when released.

A residents' guide was available in the designated centre. The residents' guide was reviewed on the day of inspection and was found to contain all of the information as required by Regulation 20.

There was a comprehensive assessment of need in place for each resident, which identified their health care, personal and social care needs. These assessments were used to inform detailed plans of care, and there were arrangements in place to carry out reviews of effectiveness. However, while residents needs had been assessed, the changing needs of one resident meant that the centre was no longer able to cater for and support their care needs. A suitable alternative living arrangement had not yet been sourced and this was impacting all residents living in the centre. While the provider was endeavouring to source suitable accommodation for them, these unmet needs presented incompatibility and safeguarding risks between residents.

Positive behaviour support plans were in place for residents, where required. The plans were up-to-date and readily available for staff to follow. In addition, staff had also completed training in positive behaviour support to ensure they were skilled and knowledgeable in how to respond to behaviours of concern and implement behaviour support recommendations and plans.

While residents' day-to-day experiences in their home were not optimal, it was

found that the person in charge and staff members endeavoured as much as possible to support residents to exercise their rights. However, due to the nature of the incidents and their frequency meant that the environment was not conducive to support all residents to exercise choice and control over their daily life, with most of the residents opting to avoid the communal living space and as a result being restricted in their movements around their own home.

The inspector found that the quality and safety of the service provided in the centre to residents was significantly compromised due to deficits and risks in relation to the assessment and meeting of residents' full needs, safeguarding and resident's rights.

Regulation 17: Premises

The registered provider had ensured that the premises was designed and laid out to meet the aims and objectives of the service and the number and needs of residents.

The centre was maintained in a good state of repair and was clean and suitably decorated. The person in charge informed the inspector that they had just been approved for new windows in early 2025 and some painting touch ups around the house.

The centre had also been adapted to meet the individual needs of residents ensuring that they had appropriate space that upheld their dignity and improved their quality of life within the designated centre. One resident had moved downstairs to accommodate their changing needs and a small living area had been converted in to a bedroom.

Judgment: Compliant

Regulation 20: Information for residents

The provider had prepared a residents' guide which had been made accessible and contained information relating to the service. This information included the facilities available in the centre, the terms and conditions of residency, information on the running of the centre and the complaints procedure.

It was evident that there was regular residents' meetings occurring weekly within the centre.The inspector reviewed four of the residents meetings minutes which demonstrated that residents were given the opportunity to express their views and preferences and were provided with information relating to the running of their centre, their rights, facilitates available and how to access additional supports should they be dissatisfied with any aspect of their care and support.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had implemented good fire safety systems including fire detection, containment and fighting equipment.

There was adequate arrangements made for the maintenance of all fire equipment and an adequate means of escape and emergency lighting arrangements. The exit doors were easily opened to aid a prompt evacuation, and the fire doors closed properly when the fire alarm activated.

Following a review of servicing records maintained in the centre, the inspector found that these were all subject to regular checks and servicing with a fire specialist company.

The inspector reviewed fire safety records, including fire drill details and the provider had demonstrated that they could safely evacuate residents under day and night time circumstances.

There was on site fire safety training on the day of inspection.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured assessments of residents' needs were completed and informed the development of personal plans. There was a comprehensive assessment of need in place for each resident, which identified their healthcare, personal and social care needs. These assessments were used to inform detailed plans of care, and there were arrangements in place to carry out reviews of effectiveness.

The inspector reviewed two residents' assessments and plans. The plans, included those on personal, health, and social care needs, were up to date, sufficiently detailed, and readily available to staff in order to guide their practice.

However, not all residents' assessed needs were being met in the centre and and this was having an adverse impact on the quality and safety of service provided to them and their peers. The provider had not ensured that the appropriate arrangements were in place to meet the needs of one resident. They had identified that the centre was not fully suitable to meet all residents' assessed needs, particularly in relation to the required living arrangements for one resident and their incompatibility with other residents, which was resulting in ongoing safeguarding

concerns.

The provider was engaging with their funder and reviewing their own internal resources to source more suitable accommodation, however they had not yet been successful. They remained committed to sourcing appropriate accommodation, and until then were utilising additional resources such as increased staffing and multidisciplinary team services.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

The provider had ensured that where residents required behavioural support, suitable arrangements were in place to provide them with this. Clear behaviour support plans were in place to guide staff on how best to support these residents, and regular multi-disciplinary input was sought in the review of residents' behavioural support interventions.

The inspector reviewed behaviour support plans in place for residents. The plans detailed proactive and reactive strategies to support residents in managing their behaviour. They were devised in consultation with the clinical team and reviewed regularly as per the providers policy.

The provider had ensured that staff had received training in the management of behaviour that is challenging and received regular refresher training in line with best practice.

The inspector found that the person in charge was promoting a restraint-free environment within the centre. The inspector completed a review of restrictive practices in place in the centre and found that all restrictive practices were logged, regularly reviewed and risk assessed in line with the provider's policy. In addition the person in charge and staff team were monitoring the use of restrictive practices and attempting to reduce the frequency of use within the designated centre.

Judgment: Compliant

Regulation 8: Protection

The registered provider had implemented systems, underpinned by written policies and procedures, to safeguard residents from abuse. Staff working in the centre completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns.

All staff were up-to-date in mandatory training in Safeguarding Vulnerable Adults.

Staff spoken with were informed of the safeguarding procedure and of their safeguarding duties.

Safeguarding incidents were notified to the safeguarding team and to the Chief Inspector of Social Services in line with regulations. However, over the past 12 months, a high number of safeguarding notifications had been submitted to the Chief Inspector of Social Services. For example, a total of 23 had been submitted to the Chief Inspector since the beginning of January 2024.

The person in charge was satisfied with the staff skill-mix and arrangements, and said that residents' needs and rights were being mostly met in the centre. The person in charge and staff told the inspector that they had concerns regarding ongoing behavioural incidents and peer-to-peer safeguarding concerns occurring in the centre and the impact these were having on residents.

They outlined to the inspector that peer-to-peer incidents were having a negative impact on the resident group. For example, their mood, sense of safety, and the overall atmosphere in the centre. They told the inspector that they had supported residents to use the provider's complaints policy and procedures to make complaints about the service in an effort to support residents' rights and to try to bring about a resolution to the situation that was ongoing in the centre.

They also spoke about some of the interventions that had been put in place. These included additional staffing, higher levels of supervision and activity planning so that residents were kept separate from each other to avoid incidents. While these measures were easing the situation, some of the interventions were restrictive in nature and therefore impacted on residents' rights to freedom and choice in their home.

The person in charge and the service manager told the inspector that the provider was engaging with their funder and external providers to source a more appropriate residential placement for one resident to address the incompatibility issues however, they had not yet been successful. This was well documented in the minutes of meetings reviewed by the inspector for example multi-disciplinary meetings, compatibility reviews, meetings with the funder and external advocacy supports. It was also further documented in management support meetings between the service manager and the person in charge held in October, July and May 2024.

The inspector found that although the provider was endeavouring to manage and implement strategies to reduce the compatibility issues in the house, the overall impact of the incidents was affecting residents' lives in a negative manner. Recently there had been a reduction in safeguarding incidents however both staff and residents expressed that this was due to the residents staying in their bedrooms and changing their routine to avoid conflict.

Without further intervention, the inspector could not be assured that residents were protected from all forms of abuse at all times. Residents are were still at risk and their quality of life is was being impacted upon in their own home.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider had ensured that the centre was operated in a manner that ensured residents had participated and consented to decisions about their care and support.

Residents' rights were discussed regularly at residents meetings. Complaints reviewed by the inspector demonstrated a consistent theme relating to residents' rights regarding their privacy and living space and ultimately the right to peace in their own home.Furthermore, residents were supported to use the provider's complaints policy and procedures and put their complaints in writing to the provider.

The inspector found evidence that the person in charge and staff team were ensuring that residents knew how to make a complaint and could freely make complaints in an accessible manner.

Complaints from service-users residents regarding safeguarding, albeit managed appropriately and in line with the provider's complaints policy and procedures, remained unresolved on the day of inspection.

Furthermore, the complaints had been escalated to the Chief Executive Officer (CEO) as per policy and the CEO had met with residents to discuss their concerns in October 2024.

Residents had access to independent advocacy services. However, despite these rights-based arrangements and systems, residents continued to experience abuse and threats of aggression, and were restricted in accessing some parts of their home due to the behaviour support needs of others.

Residents no longer wanted to live with each other and due to the nature of the incidents and their frequency demonstrating the implementation of a rights-based approach to care was proving challenging in the centre and improvements were required. As a result, the incompatibility issues and ongoing safeguarding concerns were adversely impacting on the quality and safety of the service.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Ballymun Road OSV-0002379

Inspection ID: MON-0036980

Date of inspection: 04/12/2024

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 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:
• PIC, keyworker, and relevant clinicians to review one resident's assessment of needs and support plans to ensure all needs identified have appropriate supports in place.
• PIC to complete review of goal tracker for one resident by 03.02.2025 and agree all timelines for completion with keyworkers by 17.02.2025.
• Next Multidisciplinary meeting scheduled for one resident on 31.01.2025
• The Provider is in the process of completing a compatibility review across the entire organisation to identify collective funding to support with compatibility. Report is in draft format and will be completed 31.01.2025 to present to HSE
• The Provider has identified a premises that may meet the needs of one of the residents:
- Chief Assistant Technical Services officer and architect has completed a site visit and completed a preliminary report, in relation to possible conversion of this premises in meeting the needs of all the residents.
- Architect Plans of proposed works have been completed.
- Costings of plans have been completed.
- Business case is in draft format for this conversion and will be completed by 31.01.2025 ready to be submitted to the HSE.
• A second option centre has been identified and a consultation document has been issued.
• Ongoing PBS plans in place and reviewed as required
• Regular clinical input in place.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The Provider will continue to escalate the risk identified within the centre at HSE IMR meetings until the compatibility issues within the centre are resolved.
• The Provider will continue to raise the risks within the centre with HSE local safeguarding team. Further reviews to be scheduled by the Provider by 01.03.2025.
• Regular clinical input and ICMs will continue until the compatibility issues within the centre are resolved.
• PIC and Service manager to review all risk assessments on 04.02.2025 regarding the compatibility issue in the centre and update where required.
• Next compatibly meeting scheduled for 17.01.2025 with PIC, Service Manager. Director of Adult Service and Designated officer. These meetings will remain in place until the compatibility issues within the centre are resolved
• To mitigate against compatibility issues, from 01.02.2025 an additional 0.5 wte post will be transferred into this centre to provide extra staff to support residents evening/weekend activities outside the centre
• In an effort to mitigate against further safeguarding issues and in agreement with all residents within the centre, the Provider will provide extra nights away from the centre for one resident starting in February 2025.
• Following any incident, residents will continue to be reassured and offered 1:1 support and/or clinical support where required.
• The Provider will continue to complete safeguarding audits within the centre

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Service manager will meet the residents 31.01.025 to regards to provider response to complaints and discuss options to further escalate the complaints as per providers complaints policy.
• PIC and Service Manager to review open complaints by 04.02.2025.
• PIC to provide updates to external advocates of the results of most recent HIQA Inspection regarding sub/non-compliances
• Keyworker to have monthly 1:1 meeting with their keyclient to listen/document concerns and support them in their daily life in line with their will and preference.

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 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	01/09/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	01/09/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	01/09/2025