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:	Liffey 6
Name of provider:	St John of God Community Services CLG
Address of centre:	Dublin 22
Type of inspection:	Unannounced
Date of inspection:	08 February 2023
Centre ID:	OSV-0003921
Fieldwork ID:	MON-0038848

About the designated centre

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

Liffey 6 is a designated centre operated by St. John of God Community Services. Liffey 6 provides residential services to male and female residents over the age of 18 in two separate houses in nearby separate housing estates in Co, Dublin. The maximum capacity of the combined service is eight residents. One house, a semi detached bungalow, has four bedrooms available to residents, a sitting room, a kitchen dining area, accessible showering and bathing areas and an utility area. The other house is a two storey detached house with five bedrooms available to residents. One bedroom on the ground floor is accessible with an ensuite. There are separate showering areas off the kitchen and upstairs. All residents have access to multi-disciplinary team including social workers, physiotherapists, occupational therapists, speech and language therapy and psychology. There are service vehicles available for the transport of residents and the location is also serviced well by public transport to shops, restaurants and social activities. Residents are supported by a team of social care workers and a social care leader.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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 8 February 2023	09:45hrs to 16:10hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection scheduled to monitor regulatory compliance in the designated centre. The inspector had the opportunity to meet with several of the residents in both houses that made up Liffey 6. The inspector used conversations with residents, observations of the care delivered by staff as well as a review of the documentation to form judgments on the quality of care in the centre. The inspector wore a face mask and maintained physical distancing as much as possible in interactions with residents and staff.

On arrival to the first house, the inspector was greeted by the person in charge and a staff member who were supporting residents with their morning routines. The inspector saw that staff were wearing face masks while supporting residents which was in line with current public health guidance. A symptom check for illness was completed with the inspector.

Several residents were seen to be having their breakfast and were being supported by staff. The residents appeared comfortable in their home and the kitchen and communal living areas were seen to be clean and tidy. After breakfast, one of the residents showed the inspector their bedroom. The inspector saw that it was well-maintained and was personalised with the resident's preferred photos and posters. The resident told the inspector that they had chosen the paint colour however they were not happy with it as it was a darker colour than they had expected it to be. They had planned with the person in charge to repaint the room in the coming weeks.

The person in charge then showed the inspector around the rest of the first house. The inspector saw that it was generally clean and furnished in a homely manner. Residents' portraits and art work were displayed on the walls. There was some minor maintenance required in this house including general painting and the repair of water damaged flooring in the kitchen.

Staff spoken with in this house were well-informed regarding the residents' needs and preferences. However, staff were unable to locate residents' most up-to-date care plans on the day of inspection. Staff were also unfamiliar with the arrangements for contacting the provider's infection prevention and control (IPC) lead. This will be discussed further in the quality and safety section of the report.

The inspector attended the second house which made up the footprint of the designated centre in the afternoon. Here, the inspector had the opportunity to meet residents who had returned to the house for lunch and were then getting ready to go to a community art class and out for a drive. One of the residents had recently moved to a downstairs bedroom as their needs had changed in recent months. The resident gave the inspector permission to see their bedroom. The inspector saw that it was personalised and comfortable.

Another resident returned to the designated centre later in the afternoon. They told the inspector that they had been to work and that they travelled to work independently. The resident said that they had moved to the designated centre recently and that they were happy living there.

The inspector completed a walk through of this house with the person in charge. There were more significant issues in this premises which required addressing by the provider. These included a worn and damaged carpet on the stairs and insufficient storage. The inspector was informed by the person in charge that works were also planned to the back gardens to make them more inviting to residents. Some of these issues had been known to the provider for a considerable length of time but the inspector saw that they had not been effectively addressed.

In both houses, the inspector saw that residents were in receipt of care that was provided in a kind and respectful manner. Staff and resident interactions were seen to be familiar and supportive. Staff were responsive to all of the residents' communications, including non-verbal communication and assisted residents with activities of daily living in a gentle and caring manner.

Overall, the residents appeared happy and comfortable in their homes. They were in receipt of care which was delivered in a person-centred manner. However, there were issues identified which posed a risk to the safety of residents in these houses. These issues will be discussed further in the next two sections of the report which will outline the governance and management arrangements and their impact on the quality and safety of care in the designated centre.

Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations. The inspector found that residents in this designated centre were supported by a familiar staff team and that there were clear lines of authority and accountability. However, a review was required by the provider to ensure that the management systems were effective in identifying and responding to risks in a timely manner and to ensure that the centre was being operated in line with the regulations. A number of regulations were identified as not compliant on this inspection. Some of these posed a potential risk to the safety of residents and it was not evidenced that the provider had appropriate oversight of these risks.

The inspector found that the provider had recently revised and made several changes to the management systems in this designated centre. The centre was run by a person in charge who was new to their role. They were found to be suitably qualified and experienced and were familiar with the residents living in Liffey 6.

The person in charge reported to a residential co-ordinator, who in turn reported to

a programme manager. The senior managers made themselves available to the inspector during the course of the day and were available to respond to any requests for information that was not available to the person in charge. Both of the senior managers has also been recently appointed to the management structure for this designated centre.

While the inspector was assured that there were now clear lines of authority and accountability in the designated centre, it was found that management systems had been ineffective in identifying and responding to risks in a timely manner. This resulted in a number of regulations being identified as not compliant on this inspection. These included an admission to the centre which was not in line with the admissions criteria and the failure to address actions as set out on six monthly audits in a timely manner.

The inspector also found that there were a number of risks in the designated centre which had not been identified in the provider's audits. These included the failure to submit notifications in line with the requirements of the regulations and risks in the areas of fire and infection prevention and control (IPC). These risks are described in more detail in the quality and safety section of this report.

A roster was maintained by the person in charge which demonstrated that staffing levels and qualifications were in line with the statement of purpose. The inspector spoke to several staff on the day of inspection and was informed that they felt well supported in their roles and that they enjoyed working with and supporting the residents who lived in Liffey 6. The inspector reviewed the training matrix for the staff team and saw that there were gaps in some of the required training areas

While the staff were suitably qualified, there were enhancements required by the provider to ensure that all staff were well informed regarding the provider's policies, procedures and the residents' care plans. The inspector found that there was an absence of up-to-date care plans and that staff were uncertain regarding the location of the most up-to-date care plans. This required review by the person in charge.

Additionally, while the inspector was informed that the provider had appointed a lead individual within the organisation to have oversight of IPC risks, it was found that staff were unaware of who this person was or how to contact them. Enhancements were also required by the provider to ensure that there were up-to-date and comprehensive policies available to staff to guide them in delivering safe and quality care.

Overall, the inspector was assured that there were suitably qualified and experienced stakeholders in positions of responsibility who had oversight for the designated centre. However, a full review was required by the provider to address the risks identified in this report and to ensure that the centre was being carried on in line with the regulations.

Regulation 14: Persons in charge

The provider had recently appointed a new person in charge to oversee the designated centre. The inspector had the opportunity to meet the person in charge on the inspection. They were knowledgeable regarding their role and responsibilities. The person in charge was familiar with the residents' preferences and assessed needs.

The inspector reviewed the person in charge's prescribed information in advance of the inspection. They were found to be suitably qualified and experienced to hold the role of person in charge. They had worked in social care settings for several years and had the necessary management qualifications.

The person in charge was employed in a full-time capacity. They had oversight of two houses which made up this designated centre. The person in charge was supernumerary to the roster. This allowed them sufficient management time to ensure they could meet their regulatory responsibilities.

Judgment: Compliant

Regulation 15: Staffing

The centre was staffed by a full and stable staff team. There were no vacancies at the time of inspection. Staff spoken with had been in their roles for several years and were very familiar with the residents and their support needs. It was clear that there was continuity of care for the residents in Liffey 6.

A planned and actual roster was maintained. The inspector reviewed this roster and found that the staffing levels and qualifications were in line with the centre's statement of purpose.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had effected a supervision schedule which ensured that staff were in receipt of regular supervision and support.

A training matrix was maintained in the designated centre. This required review to ensure that all staff were up-to-date with mandatory training. The inspector saw that five staff required training in managing behaviour that is challenging and three

staff required training in infection prevention and control.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were clear lines of authority and accountability in the designated centre. Staff were familiar with the management structure and of how to escalate concerns. However, due to the number of risks identified on this inspection, some of which posed a risk to the safety and well-being of residents, it was not evidenced that management systems were wholly effective in ensuring that the service was safe and appropriate to meet residents' needs.

Regular audits were completed by the provider which identified many of the risks within the service and set out the actions required to address these. However, the inspector saw that some of the risks, such as the premises issues had been identified on audits for a considerable length of time and had not been addressed by the provider. For example, the most recent six monthly audit identified that the premises works had been outstanding since the previous two six monthly audits.

The provider's audits informed a quality enhancement plan (QEP) which detailed actions and timeframes required to address risks. The inspector found that several risks, such as the lack of up-to-date assessments of need were captured on this QEP. However, other risks including those presenting a risk to the safety of residents, such as the failure of one resident to evacuate during fire drills, were not identified on audits or on the QEP. Therefore, it was not identified that the audits were effective in identifying all risks and driving continuous service improvement.

Staff in the centre were performance managed and reported that they felt supported in their roles.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

An admission to the centre was found to have been contrary to the admission criteria as set out in the centre's statement of purpose.

While the resident had been supported to visit the home before their admission and reported that they were happy living in the designated centre, there was a lack of transparent criteria identified to support this admission.

Judgment: Not compliant

Regulation 3: Statement of purpose

There was an up-to-date statement of purpose in place in the designated centre. This contained all of the information as required by the regulations. The statement of purpose had been updated to reflect the changes to the person in charge and service manager in recent months.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all adverse incidents were reported to the Chief Inspector within three working days as required by the regulations. These included:

- an outbreak of a notifiable disease in 2022
- two safeguarding incidents in 2022
- two NF40s which recorded nil incidents within six months were not fully completed

Judgment: Not compliant

Regulation 4: Written policies and procedures

The inspector reviewed the schedule 5 policies in place in the designated centre and found that many of these required review as they were out of date.

Additionally, several policies were absent from the Schedule 5 policy folder including the policy on visitors and provision of information to residents.

The provider had also not effected a policy relating to the prevention, detection and response to abuse within their organisation. While the inspector was informed that the HSE safeguarding policy was available to staff, this policy was not specific to safeguarding in designated centres and did not set out the provider's protocols to ensure that residents were protected from abuse within their organisation.

Judgment: Not compliant

Quality and safety

This section of the report details the quality and safety of the service for the residents who lived in the designated centre. Overall, the inspector found that the day-to-day practice within this centre was person-centred and supportive of the residents' preferences and choices. However, due to risks identified on the inspection, some of which had been known to the provider for a considerable length of time, it was not evidenced that this care was delivered in a environment which was safe and appropriate to meet the needs of all residents.

The inspector saw on a walk through of the premises that general painting and maintenance was required in both houses. Additionally, there was damage to the carpet in one of the houses and the flooring in the kitchen of another house. These risks had been known to the provider for over a year but had not been addressed. There was also a lack of suitable storage in the designated centre. The inspector saw that a room allocated as a snug, for residents to use, was cluttered and inaccessible as it was being used to store excess personal protective equipment (PPE) and to dry laundry.

Some of the premises issues posed a risk to infection prevention and control (IPC). For example, there was a lack of suitable laundry facilities in one of the houses. The washing machine was located in the kitchen. This had not been risk assessed to control for the potential for cross contamination due to it's location where food was also prepared. Laundry was seen to be drying in the snug of the other house which contributed to this area being inaccessible to residents.

The fire arrangements in the designated centre also required review. The inspector saw that one of the fire doors in a house was wedged open by a sofa. While the inspector was assured that this was not a standard practice and saw that this was addressed on the day, it was evident that the heavy fire doors were impacting on residents' accessibility within the house. The provider had not installed mechanisms to hold the doors open in a safe manner while ensuring that fire containment measures were not compromised.

Furthermore, a risk was identified in the other house whereby a resident did not participate in evacuation fire drills. The inspector was not assured that the provider had adequate measures in place to ensure that all residents could be safely evacuated in the event of a fire.

The provider's audits had set out that residents' assessments of need required updating. The inspector reviewed a number of residents' files on the day of inspection and saw that while they all had an assessment of need, many of these were out of date and did not comprehensively describe residents' needs. There were also insufficient care plans available for the identified assessed needs on residents' files. The storage of care plans also required review. Inconsistent practices among staff led to uncertainty regarding the location of the most up-to-date care plans.

Residents did, however, have up-to-date intimate care plans on their files. These were written in a person-centred manner and described the supports required to maintain residents' dignity and autonomy. Staff spoke with were aware of their safeguarding roles and responsibilities.

Staff were also working to ensure that residents' rights were upheld and that residents were well-informed regarding their rights. However, the oversight of restrictive practices in the centre required review to ensure that these were logged, reviewed regularly and that the least restrictive practice was in place for the shortest duration possible.

Regulation 17: Premises

The inspector completed a walk around of both houses on the day of inspection. The inspector saw that there were issues with the premises which had been long known to the provider, having been identified on at least three of the last six monthly unannounced visits. While many of these issues were not impacting on the quality of care, they did not support a homely environment for the residents.

These included:

- painting required to common areas
- absence of flooring between the hall and corridor in one house
- damage to kitchen flooring caused by a washing machine
- the carpet on the stairs in one house was very worn and required replacing
- Inadequate storage space, for example the snug in one house was being used as a storage space for PPE and laundry as there was insufficient space elsewhere in the house for storage.
- a canopy used by one resident for coverage when smoking in the garden had been removed and not replaced.
- both gardens required improvements to make them more inviting for residents to spend time in.

Judgment: Not compliant

Regulation 27: Protection against infection

There were enhancements required to the oversight of infection prevention and control in the designated centre to ensure that the centre was meeting the requirements of the national standards in this regard.

The inspector identified several risks to infection prevention control. These included:

- while all residents had individual bath mats, these were stored on top of each

other after use which did not ensure effective IPC control
- the washing machine was located in the kitchen of one of the houses. There was no risk assessment available to mitigate against the risk of contamination to food while laundry was being completed in this area
- While the inspector was informed that the provider had appointed an IPC lead for the region, the inspector found that staff were unaware of who this person was or how to contact them should they need to.
- There was no outbreak management plan in the centre or individual isolation plans to detail how to support residents to isolate

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had implemented measures to contain, detect and extinguish fires. However, the arrangements to contain fires required review to ensure that they were not impacting on residents' accessibility and mobility within the designated centre.

The inspector saw that one fire door was wedged open by a sofa. This was rectified by staff on the day of inspection. Staff informed the inspector that this was not a standard practice however they said that some residents found it difficult to open the internal fire doors due to their limited mobility. The provider had not installed mechanisms such as magnetic door holders to support accessibility while also maintaining the effectiveness of the fire containment measures.

The inspector was also not assured regarding the fire evacuation measures in place. One resident had consistently refused to evacuate the centre during fire drills. The inspector found that the provider had not implemented effective arrangements to ensure that this resident could be safely evacuated in the event of a fire.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Several residents' files were reviewed by the inspector in both houses. The statement of purpose set out that detailed care plans would be available in the centre to ensure that all staff were adequately informed of residents' care needs. However the inspector saw that, while residents had an assessment of need which had been recently updated, this assessment of need was not comprehensive and did not sufficiently detail residents' needs and the supports which were required to maximise their independence.

There was an absence of care plans for diagnosed health conditions. Therefore it was not evidenced that residents were in receipt of appropriate care as required by their health needs.

Staff were also unable to locate known care plans on the day of inspection. It was not established if the most up-to-date care plans were stored online in a database, in a shared file or in hard copy on the residents' files.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The arrangements in place in relation to restrictive practices and to staff training in behaviour support required review.

The inspector saw that several staff required training in managing behaviour that is challenging and that there was no date set for when this training would take place.

There were several restrictive practices in the designated centre which had not been logged by the provider to ensure that they were regularly reviewed. While these restrictive practices were not found to be impacting on the quality of life for residents, they nonetheless required oversight and monitoring. The provider had noted on their six-monthly review that the restrictive practices in the centre required auditing. The person in charge was aware of this and stated that they had plans in place to refer these restrictive practices to the provider's relevant committee for review. The restrictive practices included:

- an audio monitor
- a locked cupboard
- a lap belt

Judgment: Substantially compliant

Regulation 8: Protection

Staff were aware of their safeguarding roles and responsibilities. All staff had received training in Children First and Safeguarding vulnerable adults.

The inspector saw that residents had up-to-date and person-centred intimate care plans. These care plans detailed residents' preferences and the supported required to maintain dignity and autonomy.

Judgment: Compliant

Regulation 9: Residents' rights

Staff in this centre were working to maintain and uphold residents' rights. Residents' meetings were regularly held and residents were informed of their rights and the processes in place to support them in maintaining their rights. For example, staff informed the residents of the complaints procedure and of their right to make a complaint using accessible information.

Rights awareness checklists were also in place in residents' files. However, the inspector found that these checklists were not wholly accurate as they did not identify any barriers to residents' rights and the measures in place to overcome these.

Additionally, there were some restrictive practices in place in the designated centre such as the use of an audio monitor which may have been impacting on residents' rights to privacy. These had not been reviewed by the provider or notified to the chief inspector to ensure that they were the lease restrictive practice in place for the shortest duration possible.

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 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 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Liffey 6 OSV-0003921

Inspection ID: MON-0038848

Date of inspection: 08/02/2023

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: All staff are currently scheduled for any outstanding infection prevention and control training. A request for Positive Behaviour Support Training has been made to the Callan Institute, when they provide us with dates staff will complete same.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Programme Quality and Safety team who conduct 6 monthly audits of the Designated Centre have recently developed a system for escalating actions that they see incomplete on more than one inspection and/or if they note something of immediate concern that requires action. These are flagged to the Registered Provider for attention. Before the inspection there had been a walkaround completed of one location with the housing association to flag the ongoing premises issues that require completion. Another walkaround occurred of the second location on 10/02/2023. The housing association have outlined all outstanding works that they will complete. The additional actions will be completed by the SJOG Maintenance team. A full plan with timelines of completion is being developed and is currently being worked through. All personal plans will be audited (this had already commenced before the inspection),	

key workers will be been given a timeline to have all assessments and plans updated.

One resident presents an ongoing issue during fire drills. A protocol and risk assessment in place. Further work is currently being done with her, this includes trying noise cancelling earphones as it is the noise of the alarm that distresses the resident. Staff keep a wheelchair close to the residents room so that she can sit on this to be supported out during an evacuation.
A sticker will be put on her window so that emergency services will be aware of the bedroom in question.
The Fire and Safety Officer is due to visit the location to review the plans for the resident in question and any recommendations will be considered and implemented.
Personal Emergency Evacuation Plan to be updated.

Transparent lines of governance structure are in place and all staff are familiar with this structure and the roles of each line manager.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
A compatibility assessment is being developed by the service. This will be a tool to ensure that we fully assess suitability of a person moving to a location. A multidisciplinary meeting will be held prior to all proposed transitions going forward to discuss the suitability and compatibility of an individual. If all persons are not in agreement with the proposed new home setting the transfer will not occur.

The Registered Provider is aware of the issue that has been raised and the importance to improve practice in this area.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All outstanding notifications were sent retrospectively.
Moving forward all notifications will be sent within the required timeframe.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The schedule 5 policy folder was reviewed prior to the HIQA visit and the Person in Charge had compiled a list of all the out-of-date policies that need to be replaced. This has since been completed. Missing policies have also been added (cctv).

The provider is aware of the need to put in place a policy relating to the prevention, detection and response to abuse within their organisation. This has been highlighted to the Programme Quality and Safety Department. As was mentioned there is a SJOG Liffey Services Protocol in place that works alongside the HSE policy, this outlines specifics to safeguarding in designated centres and mentions provider's protocols to ensure that residents are protected from abuse.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Before the inspection there had been a walkaround completed of one location with the housing association to flag the ongoing premises issues that require completion. Another walkaround occurred of the second location on 10/02/2023. The housing association have outlined all outstanding works that they will complete. The additional actions will be completed by the SJOG Maintenance team. A full plan with timelines of completion has been put together and is currently being worked through.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• A drying rack that allows bathmats to be dried individually has been purchased.
• The washing machine is being sourced to put in the shed that will be used to wash soiled clothing.
• Staff who require additional infection control training have been scheduled for same.
• Staff have been informed of the IPC Lead and how they can support in times of need.

This will be highlighted at the next team meeting.
• There is now an outbreak management plan in each house within the Designated Centre. This includes detail on how each individual would potentially isolate if required and what supports may be required.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All doors that require self closers will be installed and/or fixed.

One resident presents an ongoing issue during fire drills. A protocol and risk assessment in place. Further work is currently being done with her, this includes trying noise cancelling earphones as it is the noise of the alarm that distresses the resident. Staff keep a wheelchair close to the residents room so that she can sit on this to be supported out during an evacuation.
A sticker will be put on her window so that emergency services will be aware of the bedroom in question.
The Fire and Safety Officer is due to visit the location to review the plans for the resident in question and any recommendations will be considered and implemented.
Personal Emergency Evacuation Plan to be updated.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All personal plans will be audited, key workers will be given a timeline to have all assessments and plans updated. Guidance provided with ensure that all care needs have appropriate corresponding care plans. Plans will ensure to also focus on maximizing independence.
A further audit of all personal plans will be done to ensure all is complete and a good reflection of the support needs required by the residents.

Regulation 7: Positive behavioural	Substantially Compliant

support	

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Positive Behaviour Support training has been requested for the staff.

All restrictions identified on the day of the inspection have now been referred to and reviewed by the regions Restrictive Practice Committee. The audio monitor has been approved as a restrictive practice and will be subject to regular review by the committee. The locked cupboard is no longer in use with immediate effect following review by the committee.

A notification was also completed retrospectively for the restrictions in Q4 of 2022.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
All restrictions in place were discussed at the Restriction Committee and guidance was provided:
This resulted in immediate removal of the locked press.
Lap belt is in place to ensure residents safety when out in her wheelchair. This has been notified to the Restriction Committee and is deemed the least restrictive option for the resident. It was notified on Q4 Nofications to HIQA and will be reviewed regularly.
Audio Monitor is in place to ensure residents safety due to his active Epilepsy. The restriction enables the resident to sleep soundly without staff having to enter his room and disturb him. This has been notified to the Restriction Committee and was notified on Q4 Nofications to HIQA and will be reviewed regularly.

The residents rights awareness checklists will be audited and recommendations provided and implemented.

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	13/09/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	13/09/2023
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	13/09/2023
Regulation 23(1)(c)	The registered provider shall ensure that management	Substantially Compliant	Yellow	13/03/2023

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	13/03/2023
Regulation 24(1)(a)	The registered provider shall ensure that each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.	Not Compliant	Orange	13/07/2023
Regulation 27	The registered provider shall	Not Compliant	Orange	13/05/2023

	ensure that residents who may be at risk of a healthcare 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.	Not Compliant	Orange	13/07/2023
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	13/07/2023
Regulation 31(1)(b)	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: an outbreak of any notifiable disease as identified and	Not Compliant	Orange	13/03/2023

	published by the Health Protection Surveillance Centre.			
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	13/03/2023
Regulation 31(4)	Where no incidents which require to be notified under (1), (2) or (3) have taken place, the registered provider shall notify the chief inspector of this fact on a six monthly basis.	Not Compliant	Orange	13/03/2023
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	13/09/2023
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where	Not Compliant	Orange	13/09/2023

	necessary, review and update them in accordance with best practice.			
Regulation 05(1)(a)	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 prior to admission to the designated centre.	Not Compliant	Orange	13/03/2023
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.	Not Compliant	Orange	13/03/2023
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in	Not Compliant	Orange	13/03/2023

	accordance with paragraph (1).			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Not Compliant	Orange	13/06/2023
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	13/09/2023
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	13/03/2023
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is	Substantially Compliant	Yellow	13/06/2023

	respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			