Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	St Michael's House Ballygall
Name of provider:	St Michael's House
Address of centre:	Dublin 11
Type of inspection:	Announced
Date of inspection:	07 December 2023
Centre ID:	OSV-0005706
Fieldwork ID:	MON-0033217

About the designated centre

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

St Michael's House Ballygall designated centre is a residential service that can support three young adults with an intellectual disability at any given time. The service can support both males and females. The centre is located in County Dublin and is a two story home which has been renovated and extended to meet the needs of three young people with autism support needs. The house has its own transport bus and is also located in close proximity to public transport and a wide variety of social, recreational, educational and training facilities. Each young person has their own bedroom and bathroom. There is a shared kitchen and dining room, three living rooms, one of which is upstairs. There is a large back garden with separate areas including a zip line, circular cycle track and other equipment for play. The house is led by a social care leader and is staffed by a mix of social care workers and health care assistants who are supported by a multidisciplinary team.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 7 December 2023	10:30hrs to 18:00hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection was an announced inspection carried out in response to the provider's application to renew registration of the designated centre.

The inspection took place over the course of one day and the inspector had the opportunity to meet with all of the residents that lived there during that time. Some family members of the residents also made themselves to speak to the inspector about their perspectives of the quality of care in the centre. The inspector used conversations with families and staff, interactions with residents, observations of interactions between staff and residents and a review of the documentation to inform judgments on the quality and safety of care being provided.

Overall, the inspector saw that the residents were living in a clean, well-maintained home which had been designed to meet their needs, including behaviour support needs, as assessed on admission. Residents had lived in this house since they were children and had, historically, presented with behaviours of concern. The provider had implemented various measures in order to respond to and manage these behaviours. These measures included environmental and physical restrictive practices.

All of the residents had aged in place and had reached adulthood at the time of the inspection. The inspector was informed that there had also been a reduction in the number of behaviours of concern for some of the residents over recent years. Therefore, restrictive practices which were used previously and required, at that time, required a comprehensive review to determine if they were still required or could be reduced. This will be discussed in more detail in the quality and safety section of the report.

The designated centre was located in a busy suburb of Dublin and was home to three residents who were all at least 18 years and older at the time of the inspection. The provider had set out, in their application to renew registration, that they intended for the centre to be registered to provide care to adults only for the next cycle of registration. This was to reflect the age range of the resident group.

A new person in charge had been recently appointed to oversee the running of the centre. They greeted the inspector at the commencement of the inspection and accompanied the inspector during a walk-around of the centre.

The centre was observed to be very clean, accessible and well-maintained internally and externally. Two transport bus vehicles were parked in the driveway of the centre and were used by residents for attending their day services and general community based activities.

The house had been sub-divided into three separate living compartments for the residents. Each resident had their own living room, accessible bathroom and

bedroom. There was also a communal dining room and kitchen. However, there were a number restrictive practices observed throughout the centre including locked doors and three quarter doors.

This meant residents could not freely access the communal areas without staff unlocking doors, and some residents could not freely move within their own compartments, for example from their living room to their bathroom or bedroom without staff facilitating this. Staff on duty carried sets of keys which were required to unlock a number of doors in the centre.

While the inspector saw that there were sufficient responsive and caring staff available to assist residents when they did express that they wanted to access another area, overall, it was unclear if the rationale for the high level of environmental restrictions was required or had been fully assessed to determine if they could be reduced or eliminated in some cases.

During conversations, with a number of staff over the course of the inspection, the rationale for the high level of restrictive practices remained unclear. For example, some residents did not have access to light switches in their bedrooms or living rooms and staff were unsure of the reason for this. Furthermore, all kitchen presses were locked, however, it was not established why this was or if there was a specific risk that required this practice to be implemented for all residents.

The recently appointed person in charge had identified the high level of restrictive practices utilised in the centre and in turn had arranged for the provider's restrictive practices monitoring committee (PAMG) to attend the centre in January 2024 and to conduct a review.

There were positive examples observed of the person in charge's initiatives to enable residents to experience more autonomy and freedom of movement in the centre. For example, in the afternoon, one resident came to the kitchen door and was supported to access the sitting room to look at the Christmas decorations and then the kitchen to make a snack.

Overall, the inspector found that staff and the person in charge were committed to providing person-centred arrangements for all residents living in the centre. Direction and support, by the provider, was required to enable to them to do so, for example in relation to reducing the level restrictive practices in the centre.

Residents' living spaces were furnished and decorated in line with their individual needs and preferences. Residents had access to sensory toys and electronic devices. Many of the residents' living spaces were decorated with pictures and photographs. The communal dining room was comfortable and homely. The centre also had a large back garden with plenty of equipment for sensory activities and recreation including a zip-line and a cycle track.

Two of residents were asleep when the inspector arrived. They were later supported to shower and get dressed by staff and to engage in activities of their choosing. A third resident was listening to music and doing a puzzle. Their living room was

pleasantly decorated with a Christmas tree and Christmas lights.

The inspector was told that one of the residents typically accessed day services. Another resident was on a priority waiting list for day services. In the interim they were being supported to engage in meaningful activities from their home. The third resident was completing their final year in school. This resident had not yet returned to school since September due to staffing difficulties in the school. However, the inspector was told that these issues had been resolved and a transition plan had been developed to support the resident to return to education in January 2024.

While there were a number of staff vacancies in the centre at the time of inspection, efforts had been made by the provider to source consistent relief and agency staff in order to ensure continuity of care. The inspector had the chance to meet and talk to some agency workers as well as regular permanent staff during the course of the inspection.

Staff spoken with were familiar with the residents and their assessed needs. Interactions between staff and residents were observed to be gentle and supportive and the inspector saw that staff were responsive to residents' verbal and non-verbal communications. Residents had access to the aids that they required to support their communication with staff in relation to their needs.

Many of the residents used facial expression, pointing and communication aids to interact with the inspector and staff. Residents generally preferred to continue with their routine and choice of activities rather than communicate about their experiences of living in the centre.

Two parents spoke to the inspector about their perspectives of the quality of care in the centre. Both parents expressed that they were very happy with the service and felt that their adult children were safe, well cared for and happy. Parents spoke about the positive changes that they have seen for their children including increased community activities and a more varied diet.

Overall, it was evident that residents were in receipt of care and support from a staff team who were endeavouring to meet the entirety of residents' assessed needs. This care and support was delivered in an individualised manner in a well-maintained house. However, enhancements were required to ensure that the restrictive practices in place were consistently monitored and to endeavour to reduce these over time in order to uphold residents' rights.

The next two sections of this report will present the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impacted on the quality and safety of care.

Capacity and capability

This section of the report describes the governance and management arrangements put in place by the provider to ensure a good quality, well-monitored and managed service to residents.

The provider had strengthened the local management arrangements of the centre with the appointment of a new person in charge which would strengthen the governance arrangements and drive service improvement for the next cycle of registration. Some improvements were required to ensure provider-led audits were driving continued improvement in the centre and utilised effectively, by the provider, to monitor the quality of service provided.

Due to changes in the management structures of the centre in the previous year, some areas of service provision had not been consistently monitored and required improvement in order to ensure regulatory compliance. As discussed, improvements were required to ensure that provider-level audits were effective in monitoring restrictive practices in the centre and measuring their impact on residents' rights, and to ensure that monitoring notifications were submitted in line with the requirements of the Regulations.

The centre was staffed by a team of social care workers and direct support workers. There had recently been some changes to the staff team and there were 3.5 whole time equivalent vacancies at the time of inspection. The provider had, however, made arrangements to ensure continuity of care by booking regular relief and agency staff. The inspector met permanent and agency staff on the day and found that they were knowledgeable regarding the residents' preferences and assessed needs.

The staff team reported to a person in charge who had recently been appointed to the management structure of this designated centre. They were suitably qualified and experienced and were further supported in their role by the service manager. The person in charge had identified areas for improvement in the service, including in the monitoring of restrictive practices, and had made arrangements to progress actions in these areas.

A number of records that were required to be maintained in the centre in were reviewed. The inspector saw that these were generally maintained as required by the Regulations. Some improvements were required to the statement of purpose to ensure that it accurately described the services provided in the centre. Additionally, the inspector found there had been some deficits in the submission of monitoring notifications to the Chief Inspector. This deficit was attributed to gaps in the oversight arrangements in the months preceding the inspection.

The provider had effected arrangements to monitor the standard and quality of care in the centre. These arrangements included unannounced audits and an annual review of the quality and safety of care. The inspector saw that these audits were comprehensive and were completed in consultation with residents, their families and staff. There were some minor improvements required to ensure that these audits identified risks in the area of restrictive practices and their potential impact on residents' rights.

Overall, the inspector found that there had been some gaps in the oversight arrangements in the past 12 months which had resulted in some areas of non-compliance. For example, the provider failed to submit the required quarterly monitoring occasions on some occasions.

However, the provider had recently appointed a new person in charge who was knowledgeable regarding the residents' and their regulatory responsibilities and who had already taken action to begin to address some of the areas for improvement identified on this inspection.

Regulation 14: Persons in charge

The provider had appointed a person in charge who was suitably qualified and experienced. They were employed in a full-time capacity and had oversight solely of the current designated centre.

The person in charge was not supernumerary however they were assigned management hours in order to fulfill their regulatory responsibilities.

The person in charge was knowledgeable regarding their regulatory responsibilities and the assessed needs of the residents in the centre.

Judgment: Compliant

Regulation 15: Staffing

The designated centre was operating with 3.5 whole time equivalent (WTE) vacancies at the time of inspection. The person in charge was attempting to ensure continuity of care by sourcing consistent relief and agency staff in order to fill gaps in the roster. The inspector was informed that the provider was actively attempting to recruit staff for the centre.

The inspector reviewed the rosters and saw that gaps were generally filled by regular relief and agency staff. The inspector had the opportunity to meet some of these staff over the course of the inspection and found that they were well-informed regarding the residents' needs and their roles and responsibilities.

However, some permanent staff communicated to the inspector that, at times, the reliance on relief and agency impacted on the quality of care for residents. For example, on occasions when agency staff were rostered on but did not have training to administer medication, this resulted in residents being able to access the community only at specific times when medications were not required to be administered.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was generally a high level of compliance with mandatory and refresher training in the centre. A training matrix was available which demonstrated that all staff were up-to-date in training in areas such as safeguarding vulnerable adults and Children First. Staff were in the process of completing refresher training in managing behaviour that is challenging.

Staff had received supervision from the new person in charge since they had commenced in their role. The person in charge showed the inspector that they had a schedule of supervisions planned for 2024 which would ensure that all staff would receive supervision in line with the provider's policy.

Judgment: Compliant

Regulation 21: Records

The inspector reviewed the Schedule 2 files for three staff who were working in the centre. These records were maintained in line with the requirements of the Regulations.

The inspector also saw that the centre maintained the following records, as required by Schedule 3 and Schedule 4 of the Regulations:

- a directory of residents
- a copy of the statement of purpose
- a copy of the resident's guide

Judgment: Compliant

Regulation 22: Insurance

The provider submitted a copy of the certificates of insurance for the designated centre along with their application to renew the certificate of registration. The inspector saw that the provider had effected buildings and contents insurance cover for the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

At the time of inspection, there were clear lines of authority and accountability in the designated centre. The centre was staffed by a team of direct support workers and social care workers who reported to a person in charge. The person in charge was further supported in their role by a service manager. However, in the months prior to the inspection, the lines of authority were not as clearly defined. This resulted in inconsistent monitoring of the service and some regulatory drift. For example, the provider failed to submit the required quarterly monitoring notifications as required by the Regulations and failed to ensure that all restrictive practices were effectively monitored.

The provider had effected a series of audits including six monthly unannounced visits and an annual review of the quality and safety of care. These audits were completed in consultation with the residents, their families and the staff team. The inspector saw that staff resourcing presented as an ongoing area of concern over the last 12 months. It was communicated to the inspector that staffing issues occasionally impacted on the quality of care provided to residents.

The six monthly audits required enhancement to ensure that they were effective in driving service improvement. In particular, improvements were required to ensure that restrictive practices were consistently monitored and reviewed and that the impact of these on residents' rights was assessed and controlled for.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A statement of purpose was in place in the designated centre. It was readily available and had been recently updated. The statement of purpose was reviewed by the inspector and was found to contain much of the information as required by Schedule 1 of the Regulations.

However, enhancements were required to ensure that the description of the services provided in the centre accurately reflected the services that residents received.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The provider had failed to submit all monitoring notifications as required by the

Regulations. These included:

- minor injuries to residents were not reported on the quarterly notifications
- regular quarterly notifications detailing the restrictive practices in the centre were not submitted to the Chief Inspector.

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 saw that residents were in receipt of care in a clean, warm home which was generally meeting the requirements of the Regulations in many areas.

However, a number of restrictive practices in place had not been adequately assessed and in some instances impacted the fire safety arrangements in the centre and could not ensure residents' rights were fully upheld.

As previously described, the premises of this designated centre was designed to give each resident their own living compartment which comprised of a living room, bedroom and accessible bathroom. The centre additionally had a communal dining room, kitchen and garden. The premises was clean and homely and provided ample communal and individual space.

There were suitable fire safety precautions and systems in place for the detection, containment and extinguishing of fires and regular fire drills were held with the residents to ensure that they could be evacuated in the event of an emergency. However, some of the restrictive practices that had been put in place had the potential to impact on the fire safety arrangements in the centre. For example, some of the three quarter doors and one door with a glass panel posed a risk to the containment of fire and to the safe evacuation of residents in the event of fire.

Additionally, many of the restrictive practices were found to be impacting on residents' rights to privacy, freedom and autonomy. A comprehensive review of the restrictive practices was required by the provider in order to mitigate against these risks and to ensure that residents' rights were upheld.

Residents in this centre had an up-to-date assessment of need which informed care plans. A sample of these were reviewed by the inspector and were found to provide clear guidance to staff on how to support residents' assessed needs, and in particular, their behaviour support needs.

However, some enhancements were required to ensure that these plans were person-centred and detailed residents' preferences and supports to maintain their

autonomy and independence in their everyday care.

Regulation 28: Fire precautions

The provider had effected mechanisms to detect and extinguish fires. There was clear guidance to staff in how to support residents to evacuate in the event of fire. Staff spoken with were informed regarding these procedures and had received training in fire safety. Fire drills were completed in the centre and the inspector saw that all residents could be safely evacuated in both day and night time scenarios.

However, some of the restrictive practices in the centre posed a risk to the safe evacuation of residents and to the effective containment of fire.

For example:

A resident's living room and bedroom doors were required to be unlocked by keys. On the afternoon of the inspection, the inspector saw that one resident's living room door could not be unlocked as the key had become jammed in the mechanism.

The inspector was told that this happened on occasion, and when it did, staff used another set of keys to unlock the door. The staff member quickly acquired keys from another staff and unlocked the door.

However, the practice of locking residents' doors using keys required review by the provider to ensure that residents could be safely evacuated in a timely manner in the event of a fire.

An upstairs door had been fitted with a glass panel. This panel had not been certified as being to the appropriate fire standard. While this was detailed as a risk on a fire safety report, there was no plan in place to address this risk.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of residents' files on the day of inspection. It was found that each file contained a comprehensive assessment of need which had been reviewed and updated within the past 12 months. The assessment of need was informed by the residents' families and the relevant multi-disciplinary professionals.

Care plans were in place for each assessed need. Care plans in one resident's file were found to be very detailed regarding the steps to mitigate against incidences of challenging behaviour. However, there was an absence of person-centredness from some of these plans. Some care plans did not include information on the resident's

preferences in relation to their personal care or how their autonomy is maintained in the delivery of care.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

There were enhancements required to the oversight of restrictive practices in this centre. The inspector found that not all restrictive practices had been identified as such or approved by the provider's monitoring committee.

Some of the restrictive practices which had not been documented included:

- no access to light switches in bedrooms or living rooms for two of the residents
- nightly hourly checks on residents
- plexi glass coverings around televisions

There was an absence of a clear rationale for other restrictive practices and the inspector was not assured that these were the least restrictive and were in place for the shortest duration. For example, residents had restricted access to the communal dining room and kitchen. It was not clearly established what the reason for this was.

Additionally, it was not clear on speaking to staff why nightly checks were required for the residents or if the impact of these checks on their right to privacy had been assessed. There was an absence of a rights restoration plan to ensure that residents' rights to freely access all parts of their home was upheld.

Some of the restrictive practices impacted on the right to privacy for residents. For example, one resident had a three-quarter door in their bedroom and living room. Staff were seen to look over the top of the door to check on the resident. There was no information available to guide staff on how to ensure that this resident's right to privacy was upheld while this restrictive practice was in place.

Enhancements were required to ensure that, where residents chose to have doors locked in line with their own preferences, that they were supported to have control and choice over this.

The inspector saw that some residents requested that staff lock their living room doors after they had entered them. However residents did not have access to keys, or other measures, for example thumb locks to allow them to lock and unlock doors themselves.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspector saw that staff interacted with residents in a kind and gentle manner. Staff were responsive to residents' communications and spoke about the supports that they used to ensure that residents were consulted with and could make choices with regards to their daily lives.

The inspector saw that residents' dignity was upheld in respect of personal care interactions which were observed during the inspection.

The family members of two of the residents took time to speak to the inspector on the day. They informed the inspector of the many positive outcomes that living in the designated centre had for their adult children.

Families described the increased opportunities that their adult children now had to engage in everyday activities including going to day services and community activities like the theatre. They described how the designated centre had enabled them, as families, to maintain caring and meaningful relationships with each other.

However, as described under Regulation 7, there were many restrictive practices in this centre which were impacting on residents' rights.

Restrictive practice arrangements in the centre were impacting on residents' rights to freedom, autonomy and privacy being upheld at all times.

The inspector saw and was told that many of the residents had presented with challenging behaviours for many years which necessitated the restrictive practices in order to safeguard them and others. However, it was unclear and not demonstrated that these restrictive practices had been comprehensively reviewed to determine that they were proportionate or continued to be required in the residents' adult lives.

The impact of these practices on residents' rights had not been assessed and rights restorations plans had not been implemented.

Judgment: Substantially compliant

Regulation 17: Premises

The premises of the centre was seen to be clean and well-maintained throughout.

Residents had access to their own individual bedrooms, living rooms and bathrooms.

Bathrooms were accessible and clean.

Residents could also access to a communal kitchen, living room and large back garden.

The garden provided facilities for physical and sensory activation.

There were photos of the residents on walls in the houses. The inspector saw that residents' living rooms contained sensory toys and their preferred activities.

Residents had easy access to aids and appliances that they required for communication and for relaxation.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 17: Premises	Compliant

Compliance Plan for St Michael's House Ballygall OSV-0005706

Inspection ID: MON-0033217

Date of inspection: 07/12/2023

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • There is a recruitment campaign currently running specifically for Ballygall, which identifies the skill mix and qualifications necessary. The management team are committed to ensuring that the current vacancies have the least amount of impact on provision of care to the residents' lives. • One new staff has recently completed on-boarding and has been offered a contract due to start on 08/01/2024. • Interviews for the outstanding vacancies of 2.5WTE are scheduled to take place on 08/01/2024. • Successful applicants will be on-boarded and fully inducted by end of quarter 1. • To ensure continuity of care, the PIC, with the support from the Relief Co-Ordinator, will endeavor to use regular internal relief staff to fill gaps in the roster, as these staff meet all SMH criteria. • Agency staff will also be available. SMH have requested to block book regular staff from the same agency, who are trained in administering medication which helps to offer stability to the team. • All staff recruited will undergo thorough probation period and will be supervised by the PIC. All staff adhere to SMH policies and procedures as per their contract of employment.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • In 2024 the Service Manager will complete an Annual Review of this service, which will include consultation with service users, families, and staff. • A minimum of two unannounced audits will also be completed by the Service Manager. • The actions from these audits will be reviewed at regular intervals throughout the year at PIC/SM meetings and this will be a standard item on the agenda. • The six-monthly unannounced audit template will be reviewed by the Quality and Safety Department, to consider including rights restrictions .This will be completed by	

end of Q1 2024.
• There will be clear recording of the duration, type and reason for a restrictive practice being deployed within the designated centre and will form part of the annual review of restrictions.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• The Statement of Purpose has been updated to reflect accurately the description of the facilities available and the services provided to the residents in Ballygall residential. The Satement of Purpose will be reviewed, annually by end of quarter 4 or as needed, by the Person in Charge and the Service Manager.
• Should changes to the Satement of Purpose be required, clarification will be sought from the assigned inspector and, if necessary, an application to vary will be submitted to the Chief Inspector.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Different timelines apply for different types of notifications i.e 3 days, 3 months or 6 months.
• The PIC will ensure that all required notifications are submitted on the HIQA portal within the required time frame. Beginning with quarter 1 notifications by 31/01/24.
• The Quality and Risk Manager will continue sending reminder emails to Person in Charges and Person Participating in Management regarding timeframes for the submission of quarterly notifications.
• Regular notifications will be scheduled in the daily diary.
• In the absence of the PIC, the PPIM has access to the portal and will ensure that all notifications are submitted within the timeframe.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The lock into residents living room has been replaced by TSD department.
• In consultation with the Fire Officer, Fire doors with vision panels and half door to Service user's sitting room will be replaced as a lifecycle issue in the organisations fire door service/maintenance program. To be completed by 31st December 2024.
• Access through all internal doors will be reviewed and risk assessed. An itemized list of door locks, which can be replaced with thumb-locks, will be sent to SMH technical Services Department to complete. This work will be completed by the end of quarter 2, 2024.
• All core staff of Ballygall are scheduled to complete unit specific fire safety training which will be completed by the end of quarter 1, 2024.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• The person in charge will support keyworkers to review and amend all support plans, particularly in relation to personal care for one resident, to include the resident's

preferences and ensure person centeredness by Jan 31st 2024. The health and development of each person continue to be promoted. All residents support plans are reviewed every quarter, and updated as needed in line with the assessed need and ensure they reflect person centeredness and the will and preferences of service users. This will be completed through key working sessions between keyworkers and service users using assisted decision-making guidelines and relevant adapted communication styles where appropriate.

Regulation 7: Positive behavioural support	Not Compliant

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

• Ballygall are committed to working towards a restraint free environment, where possible and will strive to provide residents with normal access to their environment.

• The person in charge has scheduled a review of all restrictive practices within Ballygall unit with St Michael's House Principal Psychologist and the Positive Approaches Monitoring Group (PAMG) to take place on 23/01/24. This review aims to identify what restrictions can be trialled to be eased in a safe manner, in conjunction with the assessed needs of each individual. For any restrictions that cannot be lifted, a clear rationale will be provided which will include the need for recording of same as per SMH policy on restrictive practice and in line with National Guidance.

• Individual assessments will be carried out with each service user to identify if there remains a need for nightly checks or if there are less restrictive ways to ensure service user safety at night.

• This work will be completed by end of quarter 1, 2024.

• All staff in Ballygall have been scheduled to attend in house rights-based training titled "Strengthening Rights" which is part of a wider Strengthening Disabilities Project within St Michael's House. All Ballygall staff will have completed this training by end of quarter 1, 2024.

• As part of MRT, all staff are required to undertake Positive Behaviour Support training. Three staff due to complete this training have been scheduled in to complete this by March 24.

• Ballygall endeavour to support positive risk taking and recognise resident's needs and supports required, can change over time. The PIC will ensure adequate data is collected and trends identified, by monitoring and reviewing the restrictive practice and incident management logs on a monthly basis.

• These logs will be reviewed at regular intervals throughout the year at PIC/SM meetings and this will be a standard item on the agenda

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

• Ballygall recognize that liberty and autonomy are fundamental human rights, including dignity, fairness, equality, respect, freedom to control one's life and to effectively take part in decision making regarding their own life. Staff also are aware that rights can be violated when physical or/ and environmental restraints are used.

• All staff have been scheduled to complete 'Strengthening Rights' training in the 1st quarter of 2024.

• Supporting residents to communicate their will and preference is vital. Total Communication Training has been scheduled for all staff on 21/02/2024

• Ballygall is committed to upholding each individual's rights to make their own decisions and will request appropriate assistance, for individuals who require support to give consent or make decisions about their care as required. The PIC will provide opportunities for all staff to complete ADM online training with YourOTC by end of quarter 2.
• The review of restrictive practices planned on 23/01/24 will focus on the impact on rights of restrictive practices, particularly in relation to environmental restrictions, in the first instance . A Rights restoration plan will be devised as a result of this review. This plan will be recorded, monitored and reviewed on a monthly basis.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/03/2024
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/03/2024
Regulation 23(2)(a)	The registered provider, or a person nominated	Substantially Compliant	Yellow	31/12/2024

	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.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/06/2024
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.	Substantially Compliant	Yellow	31/03/2024
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/12/2023
Regulation 31(3)(a)	The person in charge shall	Not Compliant	Orange	31/01/2024

	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 occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	31/01/2024
Regulation 05(4)(c)	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 is developed through a person centred approach with the	Substantially Compliant	Yellow	31/01/2024

	maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.			
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	31/03/2024
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.	Not Compliant	Orange	23/01/2024
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all	Not Compliant	Orange	31/03/2024

	alternative measures are considered before a restrictive procedure is used.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	31/03/2024
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is 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.	Substantially Compliant	Yellow	31/12/2024