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 4
Name of provider:	St John of God Community Services CLG
Address of centre:	Dublin 24
Type of inspection:	Unannounced
Date of inspection:	03 November 2022
Centre ID:	OSV-0005781
Fieldwork ID:	MON-0038353

About the designated centre

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

Liffey 4 is a designated centre operated by St. John of God Community Services Company Limited by Guarantee. The designated centre is comprised of two detached community houses based in West Dublin. The service provides residential care and support for up to seven residents with intellectual disabilities. Support is based on identified needs and abilities through relevant assessments. The aim of Liffey 4 is to support residents to live as independently as possible and to enable them to plan for and achieve their goals they set in their lives. Each resident has their own bedroom in each residential unit that makes up the centre. Residents are supported by a staff team of social care workers and a social care leader who holds the role of the person in charge of the centre. Residents in Liffey 4 are supported to avail of meaningful day services. The day service the individual attends depends on the individuals' needs and preferences. The residents are supported to access the community and access work and education opportunities through these day services. Where a resident has chosen not to attend a day service he/she is supported to avail of a meaningful day from their home through activities in the community.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 3 November 2022	09:15hrs to 17:25hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

This inspection was carried out following the receipt of solicited and unsolicited information by the Health Information and Quality Authority. The information received set out an ongoing incompatibility issue in one of the houses that made up the centre, resulting in peer-to-peer safeguarding incidents which were having a negative impact on residents.

Liffey 4 comprises two detached homes located in community residential settings. In line with public health restrictions, as a result of COVID-19, one of the two houses was inspected on the previous inspection. The findings from this inspection focused on house that had not been inspected previously and which was subject to the solicited and unsolicited information received by HIQA prior to this inspection.

The house inspected was home to three residents but could accommodate up to four residents in total and consisted of a two-storey property with large gardens located to the front and back. The house also had five bedrooms; one staff sleepover room, a sitting room, a kitchen dining area, two bathrooms, a utility area and a staff office.

The inspector observed the care and assistance provided by the staff team was of a good standard, and they interacted with residents in a kind and supportive manner. However, from speaking with residents and staff and observing interactions and atmosphere in the home, on the day of inspection, it was demonstrated residents were experiencing considerable stress and fear as a result of ongoing peer-to-peer safeguarding risks as a result of incompatibility of residents.

One resident, the inspector spoke with, described the distress living in the house had caused them. They expressed to the inspector their unhappiness at not feeling safe in their own home. They were angry and frustrated about having to remain in their bedroom a lot of the time, saying "I always get threatened". The resident said the staff were very nice and tried to help, but the incidents kept occurring.

The inspector spoke to a family member during the course of the inspection. They discussed their concerns regarding their relative living in the centre and the complaints they had made regarding the incompatibility of the resident group. While one complaint was under investigation, the inspector could not find documented evidence that all complaints had been investigated in line with the provider's complaints policy.

Staff, through the complaints process, had also advocated on behalf of residents, in particular residents without natural supports or independent advocates. One complaint made by staff on behalf of residents set out that residents felt "scared" in the house. The complaint stated that a resident could not leave their bedroom for long periods of time, and there were incidents of peer-to-peer intimidation and

threatening behaviour towards residents.

The response to the complaint however, did not bring about improvements in the centre or considered action by the provider given that the complaint was lodged in November 2021 and this inspection found the matters as set out in the complaint were still ongoing at the time of the inspection.

Residents were living in a highly restrictive environment where they engaged in safety-related behaviours such as staying in their bedrooms during the day, only eating in communal areas when they were alone, and planning daily routines to prevent crossover with other residents. Staff were observed to be hyper-vigilant during the inspection to residents' emotional presentations and the location of residents at all times.

A preliminary screening form reviewed by the inspector, outlined daily presentations of residents and the types of incidents that were happening. For example, some residents appearing nervous and fearful when leaving their bedroom or residents, when returning from their day service, ringing staff to ask them to open the house door so the resident could enter and move safely to their bedroom with the report concluding that the psychological wellbeing of some residents had been compromised, and the risk of physical and verbal abuse was ongoing .

Incident reports for the centre, read by the inspector, outlined examples of institutional abuse experienced by residents, For example, incidents reported that a resident ..." appeared frightened and was shaking and sobbing". Incident reports also detailed physical assaults such as being punched, kicked, hit and hair being pulled. Verbal abusive incidents such as being cursed and shouted at also had an impact on residents. The impact being, increased incidences of self-injurious behaviours and withdrawing to bedrooms as residents did not feel safe in communal areas.

However, some incidents also occurred in residents' bedrooms or could include kicking a resident's bedroom door while they were in their room. Through a review of documentation in centre such as incident reports, safeguarding plans and meetings, it was evident that staff had escalated safeguarding concerns to the best of their abilities.

Given the significant safeguarding issues identified on this inspection, observations made by the inspector and feedback received from residents, family members and staff, the inspector was not assured that the governance arrangements were effective in being able to ensure the safety and wellbeing of residents.

As a result of the high levels of non compliance found on the day of inspection and ongoing safeguarding risks presenting, the inspector took the unusual step of issuing the provider with an urgent compliance plan requiring the provider to put immediate and urgent actions in place to ensure the safeguarding and protection of residents living in the centre. The provider responded by putting in place increased staffing levels to ensure each resident had one-to-one support in an effort to mitigate safeguarding incidents from occurring.

Despite the considerable evidence to demonstrate there were numerous communication channels, oversight arrangements and reporting mechanisms that should have alerted and informed the provider to the untenable situation in the centre, it was not demonstrated that the provider had taken timely or appropriate action to address these risks to ensure a safe service for residents.

As a result, the provider was invited to attend a fitness assessment with the Office of the Chief Inspector on foot of serious concerns with regards to their fitness as provider in carrying out the business of a designated centre. This assessment would form part of the decision making around the next steps of escalation and/or enforcement action that would be taken by the Office of the Chief Inspector as a result of the findings from this inspection.

In addition, on foot of these findings, and in line with the Memorandum of Understanding between both offices, the Office of the Chief Inspector referred these matters to the National Disability Safeguarding Office, raising concerns in relation to the safeguarding incidents, potential institutional abuse occurring and the lack of evidence to demonstrate the consistent and effective implementation of National Safeguarding Vulnerable Adults policies and procedures in the centre.

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

Capacity and capability

The purpose of this inspection was to assess the provider's compliance with the regulations and standards and to follow up on the concerns and risk outlined in solicited and unsolicited information received.

Prior to the inspection, HIQA had sought a provider assurance report on foot of concerns raised about the quality and safety of the service. While a response received outlined some assurances, further information was required to establish if the safeguarding concerns were being suitably addressed.

Overall, this inspection found that despite the assurances provided, there remained considerable safeguarding concerns and risk in the centre which the provider had failed to address in a timely manner and were having a considerable negative impact on residents who were experiencing potential institutional abuse.

Despite the provider having governance and oversight arrangements to identify risk, oversee regulatory compliance and seek feedback from residents, families and staff, the provider had failed to act when these systems identified risk in the centre. This inspection found this had happened on numerous occasions and that the provider was not responsive when their own oversight mechanisms identified safeguarding

risks.

As a result, residents had experienced fear and stress on a continuous basis in their home. Despite recorded and logged complaints, provider-led audits and numerous incident reports outlining high levels of safeguarding risks in the centre, the provider had not taken any considered or timely action to meet the needs of residents and eliminate the safeguarding concerns presenting. This ultimately demonstrated the providers failure to protect residents and raised concerns regarding their fitness as a provider.

The delivery of care and support was not in line with the centre's statement of purpose, which stated its aim was to ''create an environment favourable to health and happiness'' and where ''residents are supported in a safe, warm, and secure setting that encourages growth and independence.''

As discussed, the provider submitted a provider assurance response to the Office of the Chief Inspector outlining the actions taken to mitigate identified risks outlined in unsolicited and solicited information received which included transition plans. However, this inspection found transition plans were in their infancy and there was no clear transfer pathway that had been identified and as a result safeguarding risks remained.

Additionally, the inspector identified on inspection that several of the recommended actions in the plan were measures that the provider's safety and quality team had already made in six-monthly provider-led audits from August 2022, February 2022, and October 2021, but not yet been actioned or completed.

While the provider had self-identified a number of concerns through these regulatory required six-monthly provider-led audits, corrective action had not been taken by the provider to ensure risks were minimised for residents. Therefore, the inspector was not assured that the provider had the capacity and capability to make the necessary changes or understood the impact and seriousness of these safeguarding concerns on residents living in the centre.

The centre's management team had undergone a number of changes prior to the inspection. The governance structure of the centre consisted of a person in charge who reported to a residential coordinator, who in turn reported to a programme manager. All three managers had commenced their roles in the designated centre the end of August 2022.

During the inspection, the inspector met with all three managers and each one expressed concerns about the lived experiences of residents and the steps they had taken to escalate the situation to the provider. This included three meetings with the interim regional director to discuss a resolution and identify alternative accommodation as part of transition planning to address the incompatibility issue in the centre.

While the inspector found significant concerns regarding the provider level governance oversight of this designated centre, the inspector was assured the centre, since the end of August 2022, had comprehensive direct senior management

involvement and support for the person in charge, staff and residents.

The persistent and prolonged incompatibility issues between residents had been further compounded as a result of staff shortages. At the time of this inspection, the house was operating with a number of relief staff due to two long-term staff vacancies not filled. As a result, there was an impact on the continuity of care and support for residents due to the centre's reliance on relief staff to supplement the staff duty rosters. In addition, staffing rosters maintained did not make it apparent which members of the relief staff had covered these shifts.

It was noted, however, that the new person in charge had recognised the rosters did not include all of the necessary details and discussed with the inspector their plans to update the rosters to adhere to the regulations.

The inspector was also informed that additional staffing supports had been approved the week prior to the inspection, and the provider committed to these supports through the urgent compliance plan response to the Office of the Chief Inspector the day after the inspection.

Regulation 14: Persons in charge

A new person in charge commenced in the centre at the end of August 2022. They were the fourth person in charge to work in the centre since 2020.

The inspector found that they were employed in a full-time capacity and were suitably skilled, qualified and experienced to carry out the duties associated with the role. They were actively engaged in the governance, operational management and administration of the centre and held a clear understanding and vision of the service to be provided.

The person in charge, although new to the organisation, had a clear understanding of their role and responsibilities and demonstrated good awareness of the concerns in the centre. They could evident the actions they had taken to date to address all areas of non-adherence to the regulations.

Judgment: Compliant

Regulation 15: Staffing

Prior to the inspection additional staffing hours were approved as a safeguarding measure and to support residents in one-to-one activities especially in the evening times. While the skill mix of the staff team was found to be appropriate, there was a considerable reliance on relief staff to support the core staff team. Consequently, this demonstrated that care and support was not continuous and was found to be a

cause of anxiety for the resident group and members of the staff team. Over a three-month period, 89 shifts were completed by relief staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had not ensured that residents were in receipt of good quality and safe care due to the combined impact of the longstanding safeguarding concerns and non-compliance with the regulations. As a direct result, residents' lived experience in the centre was determined to be poor.

Despite the considerable evidence to demonstrate there were numerous communication channels, oversight arrangements and reporting mechanisms that should have alerted and informed the provider to the untenable situation in the centre, it was not demonstrated that the provider had taken appropriate action to address these risks and ensure a safe service for residents to live.

It was unclear if the registered provider, being the legal entity, was suitably informed of the presenting risks in this designated centre in relation to residents' rights, safety, safeguarding and autonomy and therefore, the provider was required to review their governance and risk reporting arrangements to bring about enhanced responsiveness to risks presenting in their designated centres.

The centre was not equipped to meet the specific care and support needs of residents, and the failure of the provider to ensure robust admission practices failed to take into account the need to protect residents from abuse by their peers.

Emergency admissions into the centre were not appropriately evaluated post-admission for compatibility purposes. The inspector was informed during the inspection that a fourth resident was proposed to move into the centre, but this had not occurred due to funding issues. This did not demonstrate that the provider was aware of the gravity and impact of the consistent adverse altercations occurring between residents which should inform admission decisions to the centre.

The provider failed to act on the key concerns highlighted in their own reviews of the centre by the quality and safety team. While detailed six-month audits succinctly captured and flagged safety concerns within the centre, there was no evidence these reports had been actioned by the senior decision makers or led to positive change or outcomes for residents.

The inspector reviewed the latest unannounced audit from August 2022 during the latter half of the inspection and found the report accurately identified the same concerns found on inspection. In addition, the inspector requested copies of the previously completed audits from February 2022 and August 2021, which were received post-inspection. Again, these reports highlighted deficits in complaints management, the safeguarding of residents, the level of risk in the centre and the

absence of completed actions from previous visits. As a result the safety and wellbeing of residents was being put at risk due to the inaction of the provider.

The governance and monitoring mechanisms developed for the oversight of the centre, including incorporating actions from the six-month unannounced audits into the trackable quality enhancement plan (QEP), were not in place. Therefore progress and updates on actions were not reviewed for completion, effectiveness or barriers. The last two six-month unannounced audits also raised the concern that actions from previous audits had not been completed and should be transferred to the QEP.

The inspector concluded that the centre's governance and management were ineffective and needed considerable review because of the lack of responsiveness to their own internal audit and review processes, the findings on inspection, the negative effects on the quality and safety of residents' lives, and the significant improvements required.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

As outlined in centre's the statement of purpose, the admissions, discharges and transfers committee had the responsibility of screening all referrals, admissions, discharges and transfers to the centre, setting out in the event of an emergency admission was possible only in extreme circumstances. While as emergency admission to the centre met this criteria, improvements were required.

There was no evidence of compatibility assessments completed prior to emergency admission or formal review of the placement, at planned intervals in line with the provider's policy, after their placement.

There were documented compatibility issues between residents already living in the home when a third resident was admitted, who was also subject to the same compatibility concerns. Furthermore, a fourth resident had been proposed to move into the house however, due to funding issues, this admission did not take place as opposed to other matters being taken into consideration. The inspector was, therefore, not assured that the provider was understood the severity of the ongoing safeguarding issues while considering admissions into the house.

The admission practices of the provider did not demonstrate that they were taking into account the need to protect residents from abuse by their peers as required by Regulation 24. It was not demonstrated that consultation and consideration of the needs of residents already in the centre were taken into account as part of admission practices and procedures.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector found that incidents were not appropriately managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. The Chief inspector was not notified in relation to all incidents of a safeguarding nature occurring in the centre, in line with the requirement of the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

A complaints policy and associated procedures were in place with an easy read complaints processes on display in the designated centre.

However, the system in place to handle complaints was inefficient and did not allow for the appropriate oversight of submitted complaints or adequate follow up. For instance, there was little information available to show how complaints were reviewed, and there was no evidence to indicate what, if any, improvement actions were taken as a result of the complaints that had been logged.

Photos of the complaints officers, which formed part of the easy read information for residents, had not been updated. For example, one complaint officer had left the organisation in August 2022 but their information had not been updated.

The complaints logging form stated if a complaint remained unresolved after action was taken at a local level, it should be referred to the complaints officer. Complaints that had been raised in the centre and had remained unresolved by the local staff team, had not been reviewed by a complaints officers in line with the set out policy and procedures for managing complaints. It was therefore, not demonstrated that complaints procedures were being effectively implemented in the centre. The inspector noted there were three complaints officers identified for the centre.

In addition, it was not demonstrated that complaints logged by staff on behalf of residents received meaningful consideration or responsive action on behalf of the provider. For example, an email to staff, who were advocating for residents and had lodged a complaint on their behalf, had resulted in 11 actions being delegated to staff. with an emailed response outlining feedback on how the form had been completed. For example, the email response noted "the form does not identify the exact reason behind the complaint; it needs to be detailed, dated and examples given" and asked "what have staff done to reassure the person and keep them

safe?".

The inspector reviewed evidence of multiple submitted incident reports, safeguarding plans and behavioural charts that corroborated the complaint. Furthermore, staff were reminded that if an external party read the complaint, they would need more context and evidence to complete a thorough review. Therefore, it was not demonstrated staff were supported to make complaints or raise concerns about the quality and safety of the service or that effective action was taken on foot of a lodged complaint made by staff on behalf of residents.

A six-monthly provider-led audit for February 2022 had also had similar findings with regards to the ineffectiveness of the implementation of complaints policies and procedures in the centre. The audit stated two residents were supported to make a complaint, but the complaint did not appear to have been reviewed by the complaint's officer. As a result, the individuals at the centre of the complaints have not received a response from the complaint's officer, and the complaint is yet to be addressed in line with provider policy. In addition the provider-led audit documented, "as a matter of priority, the complaints should be forwarded to the appropriate complaint's officer".

However, the following six-monthly provider-led audit in August 2022 noted that the six recommendations made as part of the previous audit regarding complaints management, had not been completed demonstrating lack of responsive action by the provider to address this self-identified area requiring improvement.

Judgment: Not compliant

Quality and safety

This unannounced inspection highlighted significant concerns with the governance and management of this centre and the impact poor oversight arrangements were having on the care and support provided to residents. This inspection concluded that the provider was not demonstrating that they had the capacity or capabilities necessary to offer a quality service to all residents.

The inspector found the service was not safe, effective, adequately resourced, monitored, or tailored to meet the needs of the residents, all of which were known, but not addressed by the provider. As a result, the service offered did not represent a human rights-based and person-centred approach to the care and support of residents.

The provider had not put in place an organisational or designated centre-specific safeguarding policy as legally required in Schedule 5 of the regulations; instead, they had adopted the HSE policy. The failure to have a provider-led safeguarding policy led to ambiguity in the policies and procedures in place concerning safeguarding residents in the centre. While the majority of safeguarding concerns

were reported and followed up, on in line with national policy, some incidents had not been reported.

The inspector recognised that staff members did their utmost to keep residents safe and that they clearly cared about the ongoing conflict in the house. Staff had numerous documentation charts to fill out regarding the compatibility concerns, including incident reports, 'friction charts', behavioural data and sleep charts. There was also an onus on staff at times to complete preliminary safeguarding screening, which the HSE safeguarding policy, set out was the responsibility of the service manager and designated officer. This provided a further example of where the provider's failure to have in place an designated centre specific safeguarding policy was impacting on safeguarding reporting procedures.

In August 2021, a six-month provider-led unannounced audit, reported the centre had a high rated risk assessment relating to, ''the safety and wellbeing of the residents, owing to factors of ongoing friction/conflict between the residents and a significant level of safeguarding on an ongoing basis''. However, no additional control measures/actions were included in the risk assessment to help reduce or mitigate the risk being assessed. The audit outlined the listed control measures, ''do not appear to be controlling the risk sufficiently''. At the time of that audit report, one resident had 14 safeguarding plans in place, while another had nine, all based on peer-to-peer interactions.

The provider-led audit reported that the findings were, ''a strong indication that residents are not free from abuse at all times''. Therefore, residents' safety and overall quality of life are being negatively impacted upon''. A further provider-led audit, in February 2022 also identified concerns, in light of the complaints and incident details reviewed, whether the service provided was safe at all times and appropriate to each resident's needs, including psychological and emotional needs.

A centre specific policy, dated March 2021, titled, 'How to support staff with the appropriate reporting required when dealing with peer-to-peer incidents,' was in place. The purpose of the policy was to assess whether peer-to-peer disagreements were deemed safeguarding. However, it was not demonstrated that unfamiliar staff effectively understood it or how to implement it. The inspector reviewed 88 incidents logged on a chart referred to as a 'friction recording chart'. These incidents had been logged since January 2022, and ranged in scale from lowest to the highest on a 'Friction Chart Intensity Scale'. The inspector found various incidents that had not been categorised correctly, resulting in under reporting of safeguarding incidents.

Therefore, it was unclear if under reporting and logging of these incidents could be attributed to the absence of staff training in an unfamiliar scoring system specific to this centre and not utilised in the wider organisation. Again, the provider's six-month unannounced audit from August 2022 identified the requirement for an urgent review of how the staff were interpreting the intensity scale of incidents and how management were reviewing these charts and recording frameworks.

From speaking with management, to determine when action had been taken during

times of heightened altercations between residents, it was explained to the inspector that the reopening of day services in August 2021, had been identified as a possible solution to reducing safeguarding incidents and impact positively on the safety and quality of life of residents. Provider-led audits had also acknowledged this but also identified that the provider needed to continue to further review such incidents to ensure the service provided met resident's assessed needs, including psychological and emotional, setting out, "the service needs to assure themselves that outside of day service provision, consideration is given to ensuring a safe service is provided at all times and that comprehensive action plans, where required, are in place, to mitigate the risk of abuse". It was not demonstrated that this further review or monitoring of the situation, as recommended in the audit, had occurred effectively.

This inspection found that despite the provider's own six-monthly provider-led audits identifying areas of actual and potential safeguarding risk and concerns and a number of incident recording frameworks, the provider failed to take responsive action to monitor and address the ongoing safeguarding risks in the centre and as a result residents were continuing to experience a negative lived experience in their home.

Regulation 26: Risk management procedures

The procedures and processes for managing risks and responding to emergencies were unsatisfactory. The provider did not demonstrate that they were effectively responding to the sustained high levels of incidents in the centre. Incident records showed a pattern of incidents involving peer-to-peer aggression and violence coupled with incidents of self-injurious behaviour over a prolonged period of time.

The provider did not have adequate assurance mechanisms in place and was not maintaining adequate oversight of the centre. While there were numerous incidents and data being reported by the centre, it was unclear if the accumulation of such incidents had been escalated to the provider and what actions were taken by the provider to address such high frequency and impact of incidences.

The inspector identified numerous instances where risk was not being effectively managed in the centre or addressed even though it was already flagged by the provider's quality team who carried out six-monthly provider-led audits of the centre. As self-identified through the provider's six-month unannounced audits, there were multiple recommendations that either reviews of incidents had not taken place in accordance with provider policy or that risk ratings were not reflective of the presenting risks.

In February 2022 , the provider's quality and safety representatives had made recommendations around improving risk management and oversight in the centre. In August 2022, those recommendations had not been completed.

The recommendations made by the provider's own quality and safety

representatives but not addressed by the provider included:

- Reviewing of risk assessments to ensure all control measures in place are sufficient to protect the residents.
- A review of all incidents occurring in the centre, including those risk-rated as negligible or low risk, to establish an aggregate trend of incidents. Escalation of incidents to the clinical safety manager due to the high number of such incidents recorded.
- A review of risk ratings assigned to specific safeguarding risk assessments. For example, one risk assessment, relating the risk of emotional and psychological unwellness for a resident, as a result of sharing a home with a fellow house peer that has demonstrated verbal abuse towards them in a threatening manner; was not assigned a risk rating that reflected the frequency or impact on the resident and required review.
- Risk of emotional un-wellness and deterioration of mental wellbeing of a resident as a direct result of behavioural interactions from fellow peer, was risk rated a low risk and not reflective of the frequency or impact identified from recording charts and feedback from the resident themselves.

Judgment: Not compliant

Regulation 8: Protection

The provider had not ensured that residents were protected from abuse and responsive measures had not been taken by the provider to address ongoing safeguarding and compatibility issues in the centre.

Safeguarding plans which were in place were ineffective and did not prevent the re-occurrence of psychological and physical abuse. The registered provider did not implement appropriate safeguards in these cases. Overall, the provider had not taken sufficient or effective steps to ensure that residents lived in a suitable environment that was free from distress and failed to ensure their wellbeing was maintained.

While the minutes of meetings were contained in the centre of safeguarding matters, the inspector found the actions leading out from the reviews did not bring out about any considerable changes to the lived experience of residents. It was not demonstrated that the provider had comprehensive or actionable plans to address this incompatibility safeguarding concern in an effective manner.

Residents were experiencing a high level of anxiety and stress in their home as a result of the ongoing potential risk of assault and abuse in the centre on a consistent and regular basis. Therefore the frequency of recorded incidents and safeguarding plans were not reflective of the currently living environment.

Judgment: Not compliant

Regulation 9: Residents' rights

Significant improvements were required to ensure that residents were in receipt of a quality service which was operating in a person-centred manner and which was respectful of individual residents' rights. The inspector found many examples where the rights of residents were impinged upon and compromised.

- The risk of harm to residents' wellbeing and an impingement on their human rights had not been addressed.
- There were numerous restrictions on the ability of some residents to exercise choice and control over their daily lives, which resulted in negative impacts on their overall wellbeing and emotional state.
- The inspector also found that one resident's right to privacy and dignity was compromised with regard to their personal space and bedroom. Again, this issue was due to compatibility issues between residents living in the centre.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Liffey 4 OSV-0005781

Inspection ID: MON-0038353

Date of inspection: 03/11/2022

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 15: Staffing</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
Additional unfunded staffing was introduced seven days a week to give the residents 1:1 staffing since the 1st November 2022. These hours are rostered when all resident are out of their day services and in the DC. This allows for each resident to have 1:1 support every evening and at weekends. These hours will continue to be filled with regular relief staff who the residents know in the first instance and regular agency staff as a second option until one resident is supported with a move to an alternative location. This was aimed at ensuring greater protection from any form of abuse and to allow the residents to engage in activities of their choosing. The evidence to date is that this has been successful with zero physical abuse incidents recorded since the additional staff were introduced. There has also been a small reduction in NIMS with incident reviews showing no physical interactions, and fewer verbal incidents taking place. Staff try to prevent these by supporting each resident on a 1:1 basis. With the increased staffing we are in a better place to prevent, and if this is not possible, intervene in any verbal outburst immediately with redirection and reassurance offered to reduce the impact on the residents as much as possible.

One staff is on maternity leave and this line will continue to be filled by regular relief staff initially, overtime from the permanent staff team as a second option and agency staff as a third and final option. The maternity leave is due to finish in February 2023.

A second vacant line is due to a permanent staff who has been suffering the effects of long Covid. This staff member has recently had an Occupational Health Assessment with a view to returning to work. Following this review the staff member will be returning to work on a phased basis W/C 05.12.2022. This will reduce the reliance on relief, overtime or agency usage. It is anticipated that this staff member will be working their full contracted hours by 30.01.2023.</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:</td></tr>
</table>

An improved Governance and Management structure is now in place within the DC, with clear lines of communication and escalation when required up to and including the Regional Director, as follows: the Person in Charge reports directly into the Residential Coordinator, the Residential Coordinator reports directly to the Programme Manager with the Programme Manager reporting directly to the Regional Director.

In the event that the Person in Charge is unavailable the staff team will report directly to the Residential Coordinator. In the event the Person in Charge and Residential Coordinator are unavailable the staff team report to the Programme Manager. Outside of working hours the staff team have access to the on-call system which is staffed by a team of Social Care Leaders and Residential Coordinators.

In terms of oversight of the DC, improvements have also been made in this regard within the DC. The Person in Charge meets with the staff team on a weekly basis at present. The Residential Coordinator and Program Manager meet face to face on a weekly basis to review the DC. There is a monthly DC meeting that takes place between the Person in Charge, Residential Coordinator and Programme Manager and these meetings now take place in the DC. This assures the Programme Manager and Residential Coordinator in terms of atmosphere, resident well-being and any maintenance issues that could be missed as a result of zoom DC meetings. The DC meetings follow a specific template that is completed by the Person in Charge and saved on the local Person in Charge folder. Quality and Safety data is a standing item on the DC monthly meeting template. This is aimed at allowing the PIC to highlight areas of concern from a Quality and Safety perspective that the Programme Manager can escalate to the Region's Quality and Safety Committee who meet on a monthly basis.

Within the Quality and Safety data, there is a section on Safeguarding, and this section allows the PIC to again highlight any ongoing safeguarding concerns that the Programme Manager can escalate to the region's Safeguarding Committee who also meet monthly. The Programme Manager is a member of both Safeguarding and Quality and Safety Committees and minutes of the committee meeting minutes are shared between the Programme Manager and Coordinator for any items that need to be actioned.

The Programme Manager has a number of pathways open to ensure any ongoing concerns are escalated in an appropriate manner to Regional Director, CEO and Board level. As stated the Programme Manager is a member of the Quality and Safety and Safeguarding Committee added to this is a bi-weekly Management team meeting that is chaired by the Regional Director with all Liffey Region senior management in attendance. The Programme Manager is also a member of the Liffey Region Regulation Committee which is chaired by the Director of Quality and Safety, these are monthly meetings where HIQA compliance is discussed with all SJOG regions for shared learning and information gathering. Any actions that arise from any of the mentioned committees are shared with the Residential Coordinators and local managers. As a direct outcome of this inspection which highlighted deficiencies in this regard, these pathways have been strengthened and re-iterated to all local residential managers both at DC meeting and group manager meetings. The aim of this is to ensure all local managers are aware of the importance of pathways and for all levels of management to use if and when required.

In 2023 there will be a monthly meeting between the Designated Officer and the

Programme Manager and this is aimed at reviewing any PSF1's or any areas of concern on a more consistent basis. This is the first time such a regular meeting has been planned and will provide a more consistent level of governance from a safeguarding standpoint.

In addition, there is now a Governance Arrangements document which has been provided to all staff members outlining the arrangements above, ensuring staff understand the lines of communication, the importance of communicating any concerns, and how escalations are completed.

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:
To ensure going forward the Provider is confident that residents coming into our service are compatible the Programme Manager in conjunction with the Quality Manager will be devising a comprehensive compatibility assessment document. This document will be completed by the 16th of January. This document will ensure that as part of any admission process, any proposed new intake will be considered for compatibility with the existing resident's in the DC. Where it is deemed that residents may not be compatible for any reason an alternative location will be looked at regardless of the status of the incoming resident.

In the immediate term there will be no further admissions to the DC until all areas raised in this inspection have been suitably rectified and the authority is satisfied that the quality of life for all residents has improved. It is deemed as critical by the Provider that we address the current issues for the residents currently in the DC before any future vacancies can be viewed. Added to this any future vacancies will be subject to a robust compatibility assessment as outlined above along with the standard admission criteria being met.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Residential Coordinator and Person in Charge have completed a comprehensive retrospective piece of work to identify and notify the Authority of all incidents that required notification in 2022. Also included in this was a review of all 2022 NIMS, which was then also assessed by the Quality Department. All queries relating to additional information have now been addressed, ensuring an accurate detailed overview of incidents is in place. The DC now has an accurate and up to date NIMS log that is maintained on a weekly basis by the Person in Charge and Residential Coordinator. The DC also now has an accurate and up to date Safeguarding log that is maintained by the Person in Charge and Residential Coordinator in conjunction with the NIMS log.

The NIMS Log is cross checked against the Safeguarding and Notifications submitted to ensure all incidents are recorded and escalated as per regulatory and organizational policy requirements by Person in Charge on a monthly basis.

All incidents are logged in the monthly quality and safety data with explanations given for each incident. Any incident scored as moderate or above will also be subject to a moderate incident review. The Person in Charge will review any NIMS completed by staff

with the signed off NIMS coming to the Residential Coordinator for additional review, if at any stage of the two step process more information is deemed as required this will be sought from the staff member involved. NIMS data is also discussed at team meetings to ensure the frontline team are in a position to gain insight and learning from incidents.

In terms of MDT support and incidents, the Person in Charge has access to the Clinical Behavioral Specialist, Social Work team and Psychology team. The Person in Charge has utilized these supports on an ongoing basis since taking up post in August 2022. The staff team and residents have had regular sessions with all parts of the MDT as groups and on an individual basis. This has helped inform the staff team and residents of what to look out for as incidents and how to appropriately record and report same. The SJOG Quality and Safety department will also facilitate workshops for the staff team in incident reporting to ensure all staff are adhering to best practice and reporting all incidents that may occur in the DC. These workshops will be provided by the 31st January 2023.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Person in Charge has completed informal training on the complaints procedure that was held in November 2022 and facilitated by the regions Director of Nursing.

All complaints in the DC have now been appropriately logged and followed up with. The DC has an accurate and up to date complaints log that is maintained on a monthly basis by the Person in Charge and Residential Coordinator. A compliant that was received from a family member has been raised through the correct channels and the family member has been contacted by the Programme Manager to acknowledge the complaint and to identify what actions are in place to attempt to rectify the complaint. The resident's family member was reassured that the complaint is being taken seriously and this has been noted on the complaints log. All previous complaints that had been submitted have now been actioned and logged detailing what actions are in place to address areas of concern raised. Complaints data is also recorded on the monthly quality and safety spreadsheet with updates given for status of each complaint that remains open. This data is completed by the Person in Charge at a local level. The Programme Manager populates the data from each location onto the regional quality and safety data spreadsheet for the monthly quality and safety data committee meeting. This meeting is chaired by the Regional Director and provides a pathway for the Programme Manager to escalate complaints data to senior and executive management level.

The staff team have a planned session on complaints to be held by the Person in Charge on 20/12/22. The staff team have also completed the complaints training on HSEland with all certs sent to Person in Charge by 16/12/22.

The documents pertaining to the complaints officers are currently being updated and changed in the DC to reflect current complaints officers. New documents will include easy reads for the residents and will be in place by 23/12/2022.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A significant amount of work has gone into the risk management systems in place within

the DC to address the deficiencies outlined. A session was held between the Risk Manager, Quality Manager, Residential Coordinator and Person in Charge following the inspection. This session looked at the effectiveness of the current risk register and following the session the risk register has been overhauled with each risk assessment reviewed in relation to risk scoring and the effectiveness of the control measures. All risk assessments in the DC have now been reviewed and the management of the DC are assured that the risk assessments are now an accurate reflection of day to day life in the DC for the residents. All the revised risk assessments have been printed out to support staff practice in this area.

A comprehensive piece of work by the Residential Coordinator and Person in Charge has gone into the NIMS and Safeguarding data for all of 2022. This has allowed for a detailed aggregate analysis of the data and allowed management to see trends and patterns of behavior for example at certain times of the day we are more likely to see incidents occurring. This has in turn allowed us to introduce additional staffing for day duties seven days a week to reduce the likelihood of incidents occurring and therefore reducing the risk of harm to the residents. As a result of a greater understanding of the ongoing risk to the residents in the DC and the associated impacts on the residents, the risk is being managed effectively. This is evidenced by a reduction in the amount of NIMS being submitted, and while incidents are still occurring, they are verbal in nature with zero physical incidents occurring since the introduction of additional staffing. We are anticipating that we will continue to see a level of verbal incidents occurring due to the individual presentations of some residents, and incompatibility issues still present, but that we are ensuring the risk of harm and the impact to the residents is mitigated as immediately.

The Provider's Quality team have conducted two additional visits to the DC since the inspection, this is aimed at ensuring the DC's QEP is reflective of the actions raised in previous inspections. The current status of these actions has been reviewed with plans in place to ensure all actions are in progress with those already complete evidenced as such. Where possible, all QEP actions are time bound.

Pathways for escalation have been reinforced and made clearer to the Person in Charge and staff team. All incidents are now reviewed and reported as required. As evidenced in the Governance and Management section of this document there are now in place multiple pathways ensuring the flow of information from the frontline staff to Regional Director. These reinforced pathways provide assurances to the Provider that key information such as high levels of repeated incidents are not missed and will be addressed in a timely manner that protects all residents from increased levels of risk.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
It had been acknowledged prior to this inspection that in terms of protection, these residents living together was no longer a viable option. Work had commenced in terms of identifying which resident would be best suited to move to a more suitable location. These pre-inspection discussions involved the Person in Charge, Residential Coordinator, Programme Manager, Designated Officer and Regional Director. Since the inspection the resident to move to more suitable accommodation has been identified along with the location of their new home. It is anticipated that this move will be completed no later

than 31st January 2023. All residents have been informed of this coming move with an acknowledgment to the residents that the current dynamic within the house is not in line with their will and preferences.

All required retrospective NIMS and NF06's were submitted and notified to the Authority and HSE Safeguarding team by 25/11/2022.
As a result of the safeguarding submissions the HSE safeguarding team amalgamated the PSF1's for the residents in the DC. The safeguarding plans were resubmitted to be more person centered and individualized to each resident and returned to the Designated Officer on 28/11/22. These safeguarding plans have been accepted by the HSE safeguarding team with a review set for end of February 2023 when the resident identified will have moved to their new location. It is hoped that when the resident identified has moved the quality of life and level of protection for all residents will improve significantly.

To ensure the move of the resident has the best possible chance of success they will be supported by a number of staff who currently work in the DC, as this will ensure familiarity and consistency in what will be a challenging time for the resident. The Person in Charge and Programme Manager met in person with the resident's family to outline the move and the rationale behind the plan. This also assured the residents family that the aim of the move was also to protect all residents in the DC. This move will allow us to begin detailed 1:1 work with their loved one to address long standing complex issues they have that are being displayed currently through the behaviors we are seeing.

Person in Charge has also been in contact with the Providers Risk Manager to provide supports for the staff team regarding resilience training and supporting residents with behaviors that challenge. It is planned that the training will be provided in January 2023.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The Person in Charge submitted a referral to the National Advocacy Service for one resident who is the only person in the DC not with a positive family relationship, this referral was submitted on 11/11/2022. It was acknowledged during the inspection that this resident did not have a voice for them and this would be rectified via the above referral. NAS have acknowledged the referral and we are awaiting further outcomes in this regard.

With the introduction of additional staffing the residents and their rights are better protected, in particular in relation to safety within their own bedrooms. There have been no further such incidents as each resident has a 1:1 staffing.

Resident meetings continue to take place each week where residents are given the opportunity to have a say in what is happening in their own home.

As discussed in the complaints section of this document, all complaints in the DC have been reviewed and logged on a complaints log and the complaints very much have a focus on the resident's rights.

Safeguarding plans have been resubmitted to HSE safeguarding teams which have been

agreed and closed for review until late February 2023 at which time one resident will have moved. The revised safeguarding plans are aimed at protecting resident's rights and keeping them safe from abuse.

With the introduction of additional staffing we are in a position to ensure effective daily plans are in place that will allow the residents access to all areas of their home as they choose. The frontline staff and Person in Charge are acutely aware of the need to ensure the residents can have free access to all areas of their home as they wish. Residents are free to choose where and when they want to have meals, engage in recreational activities at home and in the community. Resident's wishes will be incorporated into the daily plan for the DC accordingly.

It has been acknowledged by the Provider that the current compatibility issues are not something that can be resolved in the DC. As referenced throughout and in communication with the inspector the Provider is working towards one goal which is to provide alternative accommodation to one resident to address the long term compatibility issues. It is viewed that this is the only long-term solution that will effectively rectify the issues raised in regard to protecting all resident's rights.

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(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	31/01/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/01/2023
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the	Not Compliant	Orange	31/01/2023

	lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/01/2023
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	31/01/2023
Regulation 24(1)(b)	The registered provider shall ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.	Not Compliant	Orange	31/01/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the	Not Compliant	Orange	31/01/2023

	designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
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	31/01/2023
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	31/01/2023
Regulation 34(2)(e)	The registered provider shall ensure that any measures required for improvement in response to a complaint are put in place.	Not Compliant	Orange	31/01/2023
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any	Not Compliant	Orange	31/01/2023

	action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Red	04/11/2022
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	31/01/2023
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.	Not Compliant	Orange	31/01/2023