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:	Ballyseedy House
Name of provider:	Resilience Healthcare Limited
Address of centre:	Kerry
Type of inspection:	Unannounced
Date of inspection:	07 November 2022
Centre ID:	OSV-0007763
Fieldwork ID:	MON-0037915

About the designated centre

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

Ballyseedy House is a large purpose built detached two-storey house located in a rural area, but within a short driving distance to a nearby town. The centre can provide residential/shared care accommodation for a maximum of six residents of both genders, between the ages of 18 and 65. The centre supports residents with Autism spectrum disorders, intellectual disabilities, physical needs and sensory needs. Support to residents is provided by the person in charge, a team leader and support staff. Each resident has their own en suite bedroom and other facilities in the centre include bathrooms, living rooms, dining rooms, kitchens, a laundry and a staff office.

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
Monday 7 November 2022	09:20hrs to 19:20hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

Residents met during this inspection generally did not engage verbally or directly with the inspector. Some residents though did smile at the inspector while a family member of one resident praised the care being provided. In addition, the atmosphere in the centre on the day of inspection was generally calm while staff members on duty were seen and overheard to interact appropriately with the residents they were supporting.

At the time of this inspection a total of six residents were living in this designated centre. While the inspector did met all of these residents, most of the residents did not communicate verbally nor engage directly with the inspector. As such the inspector relied on observations, discussions with staff members on duty and a discussion with the family member of one resident to get a sense of residents' experiences in their home.

On arrival at the centre, some residents were present in the communal areas of the centre being supported by staff members while other residents were in their bedrooms. At this time one resident was preparing to leave the centre to go to their day services and this resident was seen to go into a staff office to print off some photos of a shop they were going to and also to get some of their personal money which was stored in an individual locked safe in this room This resident left the centre soon after but had returned before the end of the inspection.

The remaining residents spent much of the day in the centre and it was noted that music was regularly playing in one of the centre's communal areas during this inspection. One resident in particular appeared at times to enjoy this music with this resident seen smiling on occasions while also appearing to briefly dance at other times. The same resident was also observed to move freely around the centre throughout the inspection and generally appeared calm and content while doing so.

Another resident was seen to be attended to by staff members throughout the day. At one point the resident was seen having their makeup being done by one such staff member. Later on as the resident was sat in the dining area with a different staff member, the resident smiled at the inspector and appeared to give him the thumbs up sign. When the inspector was leaving the centre at the conclusion of the inspection the resident was seen in the hall area of the centre and was again noted to be smiling.

When in this hall area the inspector noted that some doorframes and walls were chipped and marked. The inspector was informed that works to address this were due to commence in the weeks following this inspection. Aside from this the premises provided for this centre was generally seen be to clean and well-furnished. All residents had their own individual bedrooms while different communal areas were also available for residents to use at opposite ends of the centre. During the

inspection residents were observed to avail of these.

For example, one resident was seen using a coloured peg board in one communal area while a second resident was seen watching television in the same area with staff members also being present. Another resident was observed to spend a portion of the day sat in a living room and generally appeared calm during this time. Towards the end of the inspection, the resident was seen walking towards a different communal area with staff. It was later indicated that this was being done to support the resident to avail of a quieter area in the centre at that time.

Before the inspection concluded, the inspector had an opportunity to speak with the family member of one resident who lived in this centre. This family member praised the care that was being provided to their relative and spoke positively of the communication they received from the centre. In doing so they highlighted that a member of the provider's senior management had taken the time to meet them to discuss their concerns around the amount of staff turnover in the centre and the potential impact that this could be having on the resident.

Some staff members spoken with during this inspection demonstrated a good knowledge around the residents they were supporting. It was also indicated by such staff members that particular incidents occurring in the centre relating to the presentation of one resident had decreased in recent months. However, one staff did say that in response to such incidents there may be times when staff had to "clear the area" and move other residents to another part of the centre. Staff members on duty were observed and heard to interact appropriately with residents throughout this inspection while the atmosphere encountered within the centre was calm.

In summary, the family member of one resident praised the care that was provided in the centre. Residents were noted to be appropriately supported by the staff members on duty. While residents generally did not engage directly or verbally with the inspector, some residents were seen smiling while the general atmosphere was found to be calm on the day of inspection.

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

While there had been some improvements since the previous inspection, the current inspection found some similar findings to the previous HIQA inspection. This included some injuries occurring in the centre not being notified as required.

This designated centre was first registered by the Chief Inspector in January 2020

for a three year period. Since that time the centre had been inspected three times in September 2020, December 2021 and August 2022. The level of compliance with the regulations decreased across those three inspections with the August 2022 inspection finding improvements were required in various areas such as monitoring systems and the submission of required notifications amongst others. In response to that inspection the provider submitted a compliance plan outlining the measures it was going to take to come back into compliance.

However, this initial compliance plan did not provide assurances in a number of areas with the provider given a second opportunity to submit a satisfactory compliance plan. A revised response was received which provided more assurances. In submitting this revised compliance plan, the provider indicated that they would address most regulatory actions identified by 31 October 2022. As the provider had applied to renew the registration of the centre for a further three years, HIQA decided to conduct a further inspection of the centre after this date to inform a registration renewal recommendation. As such the focus of the inspection was to assess if the provider had implemented their stated actions and come into compliance in some key areas highlighted by the previous inspection.

Overall, the inspection found that there had been some improvement since the August 2022 inspection. For example, weekly audits of residents' finances were being conducted which improved the level of oversight in this area. The previous inspection had found that six monthly unannounced visits to the centre by a representative of the provider, a key regulatory requirement, were not being conducted in a timely manner. Such a visit had not been completed since the August 2022 inspection and it was indicated to the inspector that an unannounced visit was to take place the day after this HIQA inspection.

However, this inspection found some similar findings as was found during the August 2022 inspection. That inspection identified that all non-serious injuries were not being notified to the Chief Inspector on a quarterly basis as required. In the revised compliance plan response submitted the provider indicated that all such injuries would be notified. While a relevant notification was submitted since then, from reviewing records on this inspection, it was again found that not all injuries had been notified to Chief Inspector as required. For example, one instance where a resident was indicated as having a cut to the head had not been notified.

The August 2022 inspection also found that there was five staff vacancies at that time and there were occasions when some assigned staff shifts were not filled. On the current inspection it was indicated that there were now 10 staff vacancies and there remained times when some certain staff shifts were not filled. It was indicated though recruitment efforts were ongoing and while a member of the centre's management outlined strategies that the provider was considering which aimed at improving staff retention. The inspector was also informed that particular staffing levels were also maintained day and night through the use of agency staff (staff members sourced from an external organisation to the provider).

Regardless of whether staff working in a designated centre are employed directly by the provider or agency staff, under the regulations the provider is required to

maintain and make available to the Chief inspector specific documentation. At the outset of this inspection, the inspector was informed that all such documents could be accessed for agency staff working in the centre. As such the inspector specifically requested confirmation that agency staff had completed relevant training and had evidence of Garda Síochána (police) vetting in place. Information was provided toward the end of the inspection but this did not provide assurance that all agency staff were Garda vetted. In light of this the inspector requested additional assurance in this area. After granting the provider additional time, it was confirmed in the days following this inspection that such agency staff were Garda vetted when they started working in this centre.

Regulation 15: Staffing

While recruitment efforts were ongoing there was ten staff vacancies at the time of this inspection and there were times when some assigned staff shifts were not filled.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training records provided indicted that some staff were overdue refresher training in areas such as safeguarding and infection prevention and control.

Judgment: Substantially compliant

Regulation 23: Governance and management

While some improvements had been made since the previous inspection, some similar findings were identified during this inspection as were found during the August 2022 inspection. This suggested that the monitoring systems in operation continued to require improvement to ensure that all issues were identified and that stated actions were completed to ensure compliance with the regulations.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The centre's statement of purpose contained all of the required information and had

been recently updated.

Judgment: Compliant

Regulation 31: Notification of incidents

As was also found during the August 2022 inspection, not all injuries had been notified to HIQA on a quarterly basis as required.

Judgment: Not compliant

Quality and safety

There was less recorded escalated incidents occurring in the centre compared to the previous inspection. Improvements continued to be required regarding aspects of medicines management.

During the August 2022 inspection it was found that there had been an increase in incidents of a resident displaying escalated challenging behaviour, some of which had impacted other residents' rights in their home. The nature of these incidents required a re-assessment to determine if other residents were psychologically impacted by these incidents. In response to such incidents, records reviewed during the August 2022 inspection indicated that particular restrictive interventions were being followed but the records did not indicate if any alternatives were tried before the restrictive interventions were used. The August 2022 inspection also highlighted that not all staff were indicated as having read the relevant resident's positive behaviour support plan and that not all staff had completed training in de-escalation and intervention.

On the current inspection it was found that there were some incidents involving the same resident that had occurred since the previous inspection which were escalated in nature were the resident was indicated as "roaring" and banging windows and doors. However, from speaking with staff members and reviewing documentation, it was evident the number of escalated incidents occurring had decreased in September and October 2022. This was a positive development and it was noted that there had been regular input for the centre from a behavioural specialist. As with the previous inspection though, records provided generally did not indicate if other residents were present or if they had been impacted by the incidents that had occurred.

Since the August 2022 inspection each resident of the centre had been risk assessed relating to the potential impacts that escalated incidents could have on them. Most of the residents living the centre did not communicate verbally so such residents

could not tell staff the extent to which or if they had been impacted by such incidents. This was also noted during the August 2022 inspection and in response to this it was indicated in the compliance plan response for that inspection that an emotions profile would be developed for each resident. It was stated that such profiles would clearly document how residents presented when happy, sad or frightened and that social stories around living with others would also be developed.

At the outset of the current inspection, the inspector was informed that these social stories were not in the place and that the emotions profiles had not been completed. Later on during the inspection, the inspector was provided with a copy of a relevant social story which was indicated as being provided to the centre after the inspection commenced. The compliance plan for the August 2022 inspection also indicated that behaviour support plans would be reviewed and signed off by all staff. When reviewing a copy of one resident's behaviour support plan it was noted that more staff had signed this to indicate that they had read this in recent months but it was indicated to the inspector that not all staff had done this.

Other records provided on the day of the inspection suggested that most staff members had undergone relevant training in de-escalation and intervention. Such training is required under the regulations and was also highlighted as being needed in one resident's positive behaviour support plan. It was noted though that one staff member working in the centre had not completed this training at the time of inspection. The same positive behaviour support plan outlined particular intentions to try to encourage the resident to engage in positive behaviour. It also provided for the use of restrictive practices if these intentions did not work. These restrictive practice were the use of particular PRN medicines (medicines only taken as the need arises).

Records reviewed indicated that there had been times when these PRN medicines had been used, although like incidents overall, the use of these had decreased in recent months. However, when reviewing the records provided it was noted that some incident reports referenced alternative measures that were tried before using the PRN medicines but other incident reports did not. In addition, one incident report indicated that one of the PRN medicines was not administered as prescribed. When reviewing other incident reports the inspector noted some recorded instances where some residents were indicated as not getting other prescribed medicines in the mornings.

As such the inspector reviewed administration records for two different residents. It was found that prescribed medicines were generally recorded as being given but some medicines were recorded as being given at later times than prescribed. For example, one resident's morning medicines were prescribed to be given at 8am but on one recent occasion they were indicated as being given at 11:45am. Staff spoken with suggested this resident would remain asleep in bed well past 8am on occasion. Information about the residents' daily routine in their personal plan indicated that they got up between 8am and 9am. Aside from this the inspector also identified two occasions where some morning medicines were not indicated as having been given from recent administration records. Taking into account the incident reports and administration records reviewed, this did not provide assurances that medicines

were being consistently administered as prescribed.

Facilities were provided within the centre for the storage of medicines but during the August 2022 inspection it was found the security of this storage required improvement. In response the provider indicated that they had put a new lock on the door to the room where medicines presses were located and install a new security coded box with keys to these presses. At the outset of this inspection it was found that these new security measures were in place but it was seen that the door to medicines storage room was open, unlocked and unattended while the security coded box with keys to medicines presses was also unlocked with a key to one medicines press left in the presses keyhole. This was highlighted immediately to the person in the charge and the inspector did not observe any further instance of medicines being stored insecurely for the remainder of the inspection.

Regulation 10: Communication

On reviewing documentation relating to one resident, it was noted that the resident's positive behaviour support plan referenced particular communication methods to use with the resident and for all staff to use such communication methods. However, the resident's communication passport made no reference to these communication methods. The inspector was also informed that not all staff had training in this communication method but that some staff had received training in this with further training planned for 2023.

Judgment: Substantially compliant

Regulation 12: Personal possessions

New individual safes had been installed to store residents' personal finances. Logs of residents' spending were being maintained and subject to weekly audit. The inspector compared residents' personal monies in their wallets and the balances indicated on their logs and found that the amounts were equal when rounding was taken into account.

Judgment: Compliant

Regulation 27: Protection against infection

Since the previous inspection a log for recording twice daily active monitoring of residents for any potential symptoms of a respiratory illness had been introduced. This took the form of twice daily temperature checks and while some gaps were

noted in the weeks after it was introduced, in the weeks leading up to this inspection, these were being completed consistently. While ample supplies of personal protective equipment and hand gels were present in the centre, during the inspection the inspector found an expired bottle of hand gel in a prominent area (this was removed after being highlighted to the person in charge), some expired gowns and some expired antigen tests.

Judgment: Substantially compliant

Regulation 28: Fire precautions

While fire safety systems were provided for, the fire alarm in place was overdue a quarterly service at the time of inspection. Early into the inspection, the inspector observed a fire door being held open by a box which negated the intended purpose of the door. This box was removed by the person in charge shortly after. An audit on fire doors had been carried out which recommended that some specific works to be carried out on these doors. While most of these works had yet to commence, the inspector was informed that the provider was looking to engage an external contractor to carry out the works.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Based on medicines records and incident reports reviewed, medicines were not being consistently administered as prescribed in the mornings. At the outset of the inspection, medicines were seen to be stored in an unsecure manner.

Judgment: Not compliant

Regulation 7: Positive behavioural support

One staff had not completed training in de-escalation and intervention and not all staff were indicated as having read and understood a resident's positive behaviour support plan. It was noted that while some incident reports referenced alternative measures that were tried before using certain restrictive practices, other incident reports did not.

Judgment: Substantially compliant

Regulation 8: Protection

While risk assessments had been completed for each resident of the centre relating to the potential impacts that escalated incidents could have them, an emotions profile for each resident to determine how those residents present when frightened had not been completed at the time of this inspection.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 12: Personal possessions	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Ballyseedy House OSV-0007763

Inspection ID: MON-0037915

Date of inspection: 07/11/2022

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:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Regulation 15(1) Difficulty in recruiting staff in the care sector is a national concern at present. Resilience employ a full time recruitment team who along with other recruitment agencies implement continuous recruitment campaigns to source and recruit suitably qualified staff to work in the designated centre. The provider and PIC will continue their endeavours to recruit suitably qualified candidates. There are planned and actual rosters in place and in the event that staffing levels are compromised due to vacancies or sick leave the roster is adapted to support it. If staffing levels are impacted, adjustments to the roster are made, this may result in reduced staffing during the day. At no time has the safety of residents being impacted by roster adjustments. In the event that staffing levels are affected which could impact negatively on service users, in line with the centres business continuity plan this is escalated to the Regional Operations Manager and Director of Social Care. The Team lead and PIC endeavour to fill all shifts daily, there have been few occasions when one shift has not been filled this is a floating shift and at all times the minimum staffing levels were attained. 3 interviews were conducted during the w/e 25/11/22 and offers of employment have been made. Links with recruitment agencies remain ongoing	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	

Regulation 16(1)(a) All mandatory training is provided for staff entering Resilience Healthcare and the PIC endeavours to ensure that all staff receive the appropriate mandatory training as part of the employees Induction and continuous professional development.

On the day of Inspection 1 staff member was due a MAPA refresher course this has been booked for the 6th and 7th of December, 2 staff members required refreshers in IPC and SOVA, these have now been completed as of the 8/11/2022. All outstanding staff requiring PBS training will complete this on the 9th of December

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Resilience have a clearly identified management structure in the designated centre that identifies the lines of authority and accountability, specific roles, and detailed responsibilities for all areas of service provision.

Ballyseedy is supported by a full time PIC and .75 Team Lead. The service is also supported by a Regional Operations Manager who reports directly to the Director of Social Care.

A robust MDT support team comprising of PBS, OT and SLT is available to support the team in the centre with weekly catch ups.

There are appropriate management systems in place to ensure that the service provided is safe, appropriate to residents needs, is consistent and effectively monitored by the PIC supported by the Regional Operations Manager.

The PIC will through supervision, team meetings and on going assessment and training ensure that all staff are aware of their duty in practising the following:
• Safe medication practices are adhered to with full implementation of Resilience Policy
• Implementation of all MDT recommendations including the monitoring of all service users emotions at times of heightened behaviour from peers. This will be monitored by the team lead/PIC on a monthly basis and reviewed with MDT
• Reporting of all incidents of minor injuries for all service users through the incident reporting system

The PIC will ensure that all incidents of minor injuries not reportable in 3 day notification are reported in the quarterly notifications as per regulatory requirements

As outlined to the inspector the six monthly unannounced was planned to take place on the 8th of November 2022, this has been completed and the report returned.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

All 3 day reportable incidents have been reported as per regulation.

Quarterly reports with regard to use of restrictive practice and some minor injuries not requiring 3 day notification have been reported.

The PIC will ensure that all other injuries not notifiable in 3 day notification are notified quarterly as per regulatory requirement.

All staff are aware of their legal requirement to report any injury to a service user and this will remain a topic on the monthly agenda for team meetings .

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
Regulation 10(1) the registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes which may include a variety of communication methods both formal and unique to the person.
The Communication Passport for one service user reviewed by the Inspector has been updated to reflect the use of a small number of Lamh signs used as part of their overall communication system. All other service users Communication Passports will be reviewed as part of their Individual Support Plan review

Regulation 10(2) the person in charge shall ensure that all staff are aware of individual communication supports required by each resident as outlined in his or her personal plan and provide appropriate training (on the job and formal) to each staff member.
Individual communication supports are part of the overall total communication approach that are available.

Six staff currently employed in the centre have participated in LAMH training scheduled. As part of the overall communication training the SLT will complete Lamh training in early 2023. This training will be provided a number of times in the year so that new staff can avail of the opportunity to attend.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
With regard to regulation 27 a twice daily temperature checklist for all residents has been introduced which will be completed consistently.

As outlined to the inspector on the day of the inspection the expired bottle of hand gel was not one of the brands used in the centre. This was disposed of on the day.

A full review of all PPE and hand gel has been completed with no further out of date supplies in circulation.

The gowns that have expiry date in May/June of 2022 have been removed from circulation.

The Antigen tests that have an expiry date in Oct 2022 have been removed from circulation.

The PIC has made contact with the HSE to ensure that all PPE past its expiry date is removed safely and securely.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Regulation 28(2)(b)(i) the upstairs fire door that was held open by a box was down to human error. The staff team have been reminded of the fire safety regulations regarding closing of fire doors. The PIC has sourced a local registered company to install a magnetised arm on the upstsirs door thus ensuring fire safety protocols are maintained. The independent audit on fire doors which was carried out ealrier in the year recommended that some specific works be carried out on the fire doors, the newly appointed property manager and the PIC will review and progress where any recommendations are regularotry required.
Regulation 28(3)(a) All fire safety equipment is serviced regularly as per regularity requirement. The quarterly fire alarm service took place on 15/11/22.
All staff have received appropriate training in fire safety. Refresher training is scheduled for January 2023.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Regulation 29 (4)(a)
Since the inspection in August a new keypad and key lock system have been installed to ensure safe practice systems for the storage of medications. On the day of the inspection a staff member did not ensure that the door was properly closed. An automatic door release will be installed on the medication room door to ensure that the door will automatically close at all times.

Protocols are in place for all PRN medications and all staff trained to administer are aware of the Protocols which are reviewed as part of medication management training and assessment. Staff are regularly reassessed for suitability to administer medications especially where an error has occurred.

The morning time administration can be difficult at times given the will and preference of service users to remain in bed or refuse medication. All Kardex's will be reviewed in particular where a service user can potentially decide to lie in of a morning , it is planned to seek a later administration time once it is in line with GP guidance.

The shift lead is assigned to administer morning medication or to assign it to another staff member. The Team Lead or PIC will link in daily each morning to ensure that all medication has been administered as per Kardex and Resilience Policy.

In the event of a medication error occurring learnings will be reviewed at team meetings or individual supervision and if required further assessment will be completed with

individuals.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Regulation 7(1) The person in charge will ensure that staff have up to date knowledge and skills which will allow them to respond to behaviour that is challenging and to support residents to manage their behaviour.

All staff with the exception of 3 newer staff have completed PBS training, a further course is scheduled for the 9th of December which the remaining staff will attend.

Regulation 7(2) 1 staff member (and 1 regular agency worker) are due to participate in a MAPA course which is scheduled for the 6th and 7th of December.

Regulation 7 (5) (b) All PBS support plans are discussed at team meetings and the PBS specialist links in on a weekly basis for updates on each service user. At all times a last resort for use of any restriction is followed and where a planned restriction has been used staff will clearly outline the proactive strategies used to de escalate prior to implementing the Restrictive Practice. All incidents where a Restrictive Practice has been used will be reviewed at team meetings and if relevant with the PBS Specialist for any learnings.

A monthly monitoring tool for all individuals MDT recommendations will be implemented by the Team Lead who will ensure that detailed recordings are maintained which will in turn monitor the progress and effectiveness of the plan. The Emotions Chart for each service user will be monitored and reviewed as part of this which will enable the MDT to determine where further supports may be required by certain individuals.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All staff are trained in the Safeguarding of Vulnerable Adults and Children First. The centre is specific to supporting people with a diagnosis of ASD, all of whom have varying levels of communication and some behavioural difficulties. Social Stories are in place to support each individual to develop knowledge and provide them with skills to protect themselves in vulnerable situations. The Emotions Chart for each individual has been implemented and will be used as an overall support for a total communication approach being utilised in the centre. It is hoped that the consistent approach will support developing an Emotions Profile for each individual that will determine the effects of other peoples behaviour, and how best to limit any emotional impact for each individual using a Rights based approach. On going monitoring will be required.

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	31/01/2023
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	31/01/2023
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	Substantially Compliant	Yellow	30/06/2023

	statement of purpose and the size and layout of the designated centre.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	07/12/2022
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	31/01/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections	Substantially Compliant	Yellow	09/11/2022

	published by the Authority.			
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Substantially Compliant	Yellow	31/03/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	15/11/2022
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	09/11/2022
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to	Not Compliant	Orange	31/12/2022

	ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
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	31/01/2023
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	09/12/2022
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and	Substantially Compliant	Yellow	07/12/2022

	intervention techniques.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Substantially Compliant	Yellow	31/01/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2022