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:	Rose Lodge
Name of provider:	Resilience Healthcare Limited
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	17 October 2023
Centre ID:	OSV-0008576
Fieldwork ID:	MON-0041257

About the designated centre

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

Rose Lodge is a designated centre which can provide full-time residential services for up to four male or female adult residents. It is situated on the outskirts of a large town in Co. Kildare. There are a number of vehicles available in the centre to support residents to visit their family and friends and to access their local community. Rose Lodge can provide a high support service for adults with Prader-Willi Syndrome who may present with complex medical and behavioural needs. The house is sub divided into four self-contained apartments and there are a number of communal areas such as a living room, sunroom, kitchen, utility room, and office. Residents' apartments have a living room, kitchenette, bedroom and bathroom. There is a driveway at the front of the house and a garden to the back. Residents are supported 24/7 by a staff team consisting of a person in charge, service manager, and support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 17 October 2023	10:00hrs to 16:30hrs	Marie Byrne	Lead
Tuesday 17 October 2023	10:00hrs to 16:30hrs	Sarah Cronin	Support

What residents told us and what inspectors observed

This risk-based inspection was completed following receipt of solicited information from this designated centre. This solicited information related to the notification of four allegations of abuse, and two serious injuries to a resident where medical or hospital treatment was required. These had been submitted to the Chief Inspector of Social Services, since the centre began operating in July of this year. Additional information was requested from the provider in relation to three of these notifications and sufficient assurances were not provided to demonstrate that the provider was being responsive and implementing the required control measures to reduce the presenting risks.

Overall, the findings of this inspection were that while the provider had policies, procedures, guidance and systems in place, these were not being fully implemented or proving effective at the time of the inspection. The inspection found poor levels of compliance in a number of areas such as staffing numbers and continuity of care, staff training and supervision, the provider's oversight and monitoring of care and support for residents, risk management, fire precautions, medicines management, and safeguarding and protection. An immediate action was issued to the provider during the inspection in relation to fire safety and due to the high levels of non-compliance found on this inspection, the provider was invited by the Chief Inspector to attend a cautionary meeting.

This designated centre is a large two-storey house located in a rural setting outside a town in Co. Kildare. The centre opened in July 2023 and is currently home to three adults who have a diagnosis of Prader-Willi Syndrome. A fourth resident was due to transition into the centre in the weeks after the inspection. The house has four self-contained apartments for residents and a communal sitting room leading to a large dining room. There is a large kitchen, a utility room and a staff office. At the rear of the house was a large shed which was in the process of being converted into a staff office and gym for residents to use. Residents had transitioned into the centre three months prior to the inspection taking place and were young adults who had come into residential services from their family homes. The inspection was facilitated by the person in charge and the service manager who reported directly to them. The service manager spoke about supporting relationships which were important to the residents and residents were driven long distances to visit family members, in addition to phone calls and video calls. It was evident that consultation had taken place with families and multidisciplinary teams who had worked with the residents to inform their transition.

Inspectors had the opportunity to meet with all of the residents on the day of the inspection. All of the residents communicated verbally. On arrival, residents were doing fire training with an external trainer with the staff team. Later in the day, each resident showed an inspector their apartment. Residents held their own key to their apartments, with two of them located on the ground floor, and the third located on the first floor. Apartments were found to be very spacious and nicely decorated.

Residents had their own sitting room, kitchenette, bedroom and bathroom. These had been personalised with photographs and residents had access to art supplies, tablet devices and a smart television. One of the residents told the inspector that they loved living in the house. Another told the inspector that they loved having a bath and had bath bombs in their bathroom to use. One spoke about being a member of a local gym and the equipment they used in the gym. They reported that they enjoyed it there.

Residents had a 'wrap-around' service in the centre which meant that they engaged in activities with the support of staff working in the house. There were two vehicles for residents to use in the centre. On the day of the inspection, some residents were going to the gym while another was going shopping. Weekly planners were in place for residents and these were in their bedrooms and accessible in the kitchen for staff to share. A review of these planners showed that residents engaged in activities such as going out for drives, going to the gym, movie nights, arts and crafts, shopping, meditation and going to a local park. Residents had their own bank accounts and were being supported with money management at the time of the inspection.

Residents had input into their menus in consultation with their dietitian. Structure and routine in relation to meal planning and meal times were in place to best support residents. There were some restrictive practices in use in the centre. For example, locked doors to kitchen and bathroom areas which were communal. There was a clear rationale and evidence base for their use. All residents had their own bathrooms which they freely accessed.

Residents had complex healthcare needs associated with their diagnosis. The provider had facilitated and accommodated access to health and social care professionals which they required in line with their assessed needs. They had registered with a local general practitioner and had input from health and social care professionals such as behaviour support specialists, dietetics and occupational therapy. Where residents required input from medical consultants, this was facilitated. Residents had health action plans in place where they were required to ensure their health was closely monitored and promoted.

Throughout the inspection, inspectors observed kind, caring and respectful interactions between residents and staff. Residents appeared comfortable in the presence of staff and with the levels of support offered to them. Staff were observed to be familiar with residents' communication preferences and to spend time chatting with them at different times during the inspection. When speaking with inspectors, staff described residents' likes, dislikes, and talents. They spoke about how residents liked to spend their time and how they supported and encourage their independence.

The majority of staff had completed online human rights training. One staff member spoke with an inspector about what they had learned and how they were implementing what they had learned into practice. They spoke about how residents had the same rights as everyone else, including the right to life they want to live. They spoke about working with the staff team to ensure that residents' rights were

respected and that they were supported to develop and achieve their goals. They spoke about the importance of residents making choices and decisions on a daily basis.

In summary, from what residents told us and what inspectors observed, it was evident that residents were living in a comfortable home and were supported with engaging in activities of their choice. However, inspectors were not assured that there was adequate oversight and monitoring of the centre particularly relating to fire safety, risk management, positive behaviour support, safeguarding and protection and medicines management. In addition, the centre was not staffed in line with the centre's statement of purpose which was impacting on care and support for residents and a number of staff had not completed training in line with the provider's policies or residents' assessed needs.

The next two sections of the report present the inspection findings in relation to the governance and management arrangements in the centre, and how these arrangements impacted on the quality and safety of residents' care.

Capacity and capability

As outlined earlier in this report, this was an unannounced inspection which was carried out following receipt of solicited information from the centre in the form of notifications. Assurances were sought from the provider in relation to a number of these notifications prior to the inspection, but the responses did not give suitable assurances that the provider was taking the necessary steps to reduce some risks.

Inspectors found that the governance and management arrangements in the centre were not proving effective in monitoring and overseeing the quality and safety of care and support in the centre. There were clearly defined management structures in place with a person in charge who was supported by a service manager who reported into them. There had been a recent change in the management structure with service manager leaving. They were replaced by a service manager who was transferred from another designated centre just before the inspection. The person in charge was also identified as such for another designated centre which was a significant distance from this centre. They shared their time between this and the other designated centre. In their absence the service manager was on duty Monday to Friday, and there was an on-call manager for evenings and weekends. The person in charge reported to a regional operations manager, who in turn reported to the director of social care.

The provider had a number of policies, procedures, processes and systems in place. However, some of these were not being fully implemented at the time of the inspection and as a result areas where improvements were required were not being identified by the provider. For example, the omission of the administration residents' medicines were not being picked up during stock control checks. In addition, safeguarding concerns were not being recognised or reported as such, and a

number of risks had not been picked up on in health and safety audits, such as fire doors which were not working properly. As part of the provider's systems for oversight and monitoring there were plans to complete six monthly and an annual review of care and support; however, this were not due to be completed as the centre was not operating for 6 months at the time of the inspection.

Inspectors found that the centre was not staffed in line with the centre's statement of purpose. There were 2.5 whole time equivalent (WTE) staff vacancies, including two WTE nursing vacancies. This was found to be impacting on the continuity of care and support for residents and this will be further detailed under Regulation 15.

Staff could access training and refresher training in line with the provider's policies and residents' assessed needs; however, a number of staff required training in key areas related to residents' assessed needs and these will be detailed under Regulation 16. There was a staff supervision schedule in place and as the centre was newly opened some staff were having probation meetings. From the sample of probation and supervision meetings reviewed agenda items varied and focused on staff's roles and responsibilities in relation to residents' care and support. However, these meetings were not proving fully effective as inspectors found a number of areas where some staff were not fully implementing the provider's policies and procedures. Team meetings were occurring regularly and the set agenda included topics such as, complaints, incidents, accidents, safeguarding, and medicines management. However, from reviewing a sample of these minutes these topics were not being regularly discussed at these meetings.

Regulation 15: Staffing

Inspectors found that the number, qualifications and skill mix of staff was not in line with the provider's Statement of Purpose, nor was it appropriate to meet the residents' assessed needs. There were staff vacancies on the day of the inspection. These vacancies were found to have an impact on the continuity of care and support for residents. For example, over a three week period prior to the inspection, 25 shifts were covered by six different relief or agency staff, and five shifts went uncovered. In addition, the statement of purpose outlined that two WTE nurses were required to meet the assessed needs of residents and there were two WTE nursing vacancies at the time of the inspection. Inspectors were informed that the provider was working to recruit to fill these vacancies. As an interim measure, where residents' required nursing support, this was sought outside of the centre.

Maintenance of planned and actual rosters required improvement. For example, some did not contain the full name of staff or what their role was.

Judgment: Not compliant

Regulation 16: Training and staff development

For the most part, staff had completed training and refresher training in line with the provider's policies and residents' assessed needs. However, a number of staff required training in areas which were deemed as required to best meet residents' assessed needs. These included managing behaviours of concern, positive behaviour support, training on Prader-Willi syndrome and training in first aid. Other courses which the provider had identified as required were hand hygiene, and infection prevention and control training. Nine staff had completed human rights training. One staff spoke with an inspector about the impact of this training which was captured in the "What residents told us and what inspectors observed" section of this report.

Staff supervision was being completed; however, inspectors found that some staff training and support was required to ensure that staff were carrying out their roles and responsibilities to the best of their ability, and in line with the provider's policies and procedures.

Judgment: Not compliant

Regulation 23: Governance and management

The governance and management arrangement in the centre at the time of the inspection were found to be ineffective in ensuring adequate oversight of care and support for residents. The provider had a number of systems to ensure monitoring and oversight of care and support; however, they were not being fully implemented in the centre at the time of the inspection. There were audit and other templates in place but some of these were not being used at the time of the inspection, and some of the audits that were being completed were not picking up on areas where improvements were required. Inspectors found that the person in charge and the new service manager were picking up on some of the areas areas for improvement. Some of these areas were in line with inspection findings. However, they required time to complete audits and to implement the required actions to ensure the ongoing safety and quality of care of residents in the centre.

The six monthly and annual review by the provider were not due to be completed at the time of the inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

A record was maintained of all incidents and adverse events in the centre. The provider had notified the Office of the Chief Inspector of the occurrence of certain events in line with regulatory requirements. However, four notifications relating to allegations of abuse had not been notified as required by the regulation.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The policies required under Schedule 5 of the Regulations were available in the centre, and had been reviewed in line with the required time frame.

Judgment: Compliant

Quality and safety

Overall, residents appeared comfortable and content in their home and were supported to engage in activities they enjoyed. Work was ongoing to support them to settle into the centre, and to develop their goals. Residents were actively supported and encouraged to connect with their family and friends. However, inspectors were not assured that there was clear monitoring and oversight of fire safety, risk management, medicines management, positive behaviour support, and safeguarding and protection.

The premises was designed and laid out to meet the number and needs of residents living there. Residents' apartments were personalised to suit their tastes. The house and apartments were warm, clean and well maintained. Communal areas were spacious and attractive spaces.

There were suitable facilities to store food hygienically and adequate quantities of food and drinks available in the centre. The fridge and presses were stocked with lots of different food items, including fruit and vegetables. There were color coded chopping boards for food preparation. Residents had specialised diets and were regularly consulting with the dietitian about their plans.

The provider had a risk management policy which contained the required information. It was detailed in nature and guided staff practice. While there were clear risk management systems in place in the centre, inspectors found that they were not being fully implemented in the centre. For example, the provider had a detailed online system in place to report any incidents or accidents and there were general risk assessments and each resident had individual risk assessments. However, the risk ratings required review to ensure that ratings were reflective of the risk. In addition, some risk assessments lacked the required detail to guide staff

practice in relation to the control measures to be implemented. While incidents were well documented, inspectors found that risk assessments and residents' plans had not been updated to reflect these. This will be detailed further under Regulation 26.

Residents were not fully protected by the fire safety precautions in the centre. There was fire fighting equipment in place and systems to ensure it was serviced and maintained. There was emergency lighting in place and systems to ensure this was serviced and maintained. There were fire doors in areas where the provider's fire safety expert had advised. However, on the day of the inspection, inspectors found a number of fire doors that were not fully operating. In addition, from a review of fire drill records in the centre it was not clear that each each resident was fully aware of the procedure to be followed in the event of a fire, or that adequate arrangements were in place to ensure that each resident could evacuate safely. An urgent compliance plan was issued to the provider in relation to fire safely and this will be discussed further under Regulation 28.

Overall, inspectors found that the systems in place to ensure the safe management of medication required improvement. The provider had policies and procedures in place and staff had completed training in the safe administration of medicines. However, inspectors identified a number of issues which required improvement in a number of areas including omission of medications, poor stock control and documentation. These are detailed under Regulation 29: medicines management below.

Residents were supported by a behaviour specialist and had interim behaviour support plans in place. These were detailed in nature; however, some documentation required review as it contained conflicting information. For example, one section of behaviour support plans did not clearly guide staff practice in relation to the use of physical holds. There were a number of restrictive practices in place and these were being reviewed regularly to ensure they were the least restrictive, for the shortest duration.

The provider had a safeguarding policy in place and staff had completed safeguarding training. While some allegations of abuse had been followed up on in line with the provider's and national policy, while reviewing incident reports inspectors found four allegations of abuse that had not been recognised, reported, or followed up on. In addition, a review of the safeguarding plans in the centre found that some of the control measures were not fully implemented.

Regulation 11: Visits

The provider had a visiting policy and the arrangements for visits were detailed in the statement of purpose and residents' guide. both of which were available in the centre. Residents were meeting with, and spending time with their families regularly. There were a number of spaces in the house for residents to meet their visitors in private if they wished to, including their apartments. There were also a

number of communal spaces in the house.

Judgment: Compliant

Regulation 17: Premises

The design and layout of the centre had been carefully considered to ensure that residents had access to and accessible, safe and comfortable home. The house and residents' apartments were tastefully decorated to meet their needs and wishes. Each resident had their own apartment and they could also access a number of communal areas in the house. During the inspection residents were observed to spend time in both the communal areas and in their apartments.

Judgment: Compliant

Regulation 18: Food and nutrition

The person in charge had ensured that there was adequate provision for the storage of food and that each resident was provided with adequate quantities of food which were wholesome and nutritious and in line with each individuals' dietary needs. All of the residents living in the centre had specialised dietary needs. Inspectors found that residents had regular consultation with a dietitian. There were set menu plans for food and fluids each day in line with assessed dietary needs. Weights were monitored and reviewed and plans were adapted with residents' input where required.

Judgment: Compliant

Regulation 20: Information for residents

There was a residents' guide which had been recently reviewed and it contained the information required by the regulations. A copy was available in the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had a risk management policy in place which met regulatory

requirements. However, systems in relation to risk management required review.

- A review of all incidents which had taken place in the centre was carried out by the inspector. This indicated a number of risks. While these risks were identified, their risk ratings were not proportionate to the ratings given to risks. Control measures were not detailed, and therefore did not give adequate guidance to staff on the actions required of them to mitigate against risks.
- Inspectors did not see evidence of clear oversight of the risk levels in the centre and review dates. For example, there was a risk assessment on fire doors prior to the centre's opening in May 2023. However, an immediate action on fire doors was required on the day of the inspection, indicating that this risk had not been rated or elevated to mitigate against the risk of fire.
- Risk assessments for individual residents also required review to ensure that ratings were reflective of the levels of risk involved.
- While incidents were a standing agenda item on staff meetings, inspectors did not see evidence that incidents and learning from these incidents were regularly discussed and shared.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors found that residents were not fully protected by the fire safety systems in the centre. As previously mentioned, an immediate action was issued to the provider during the inspection in relation to fire containment and fire evacuation. There were a number of fire doors which were not fully operational on the day, and a fire drill had not been completed when all residents and the least amount of staff were present. In addition, discrepancies were found across documentation relating to fire safety. For example, one residents risk assessment referred to them choosing not to participate in a fire drill; however, the fire drill records stated that they had evacuated successfully. In addition, their personal emergency evacuation plan was not found to contain sufficient detail to guide staff.

The provider responded to an urgent compliance plan request within 48 hours and provided assurances that a fire drill had been simulated, that fire doors had been fixed, that readjustments were made to one fire door while a replacement was ordered, and that the necessary documentation had been updated. The provider also indicated in their response that they were reviewing the types of door closers they used in the centre.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors found that policies and procedures relating to medicines management were not being fully implemented in the centre and this was resulting in errors and omissions. Medication audits and checks were not identifying these issues. For example, while reviewing a sample of residents' records an inspector picked up on number of documentation errors, a number of occasions where residents' prescribed medicines had not been administered as prescribed, and one occasion where a resident was administered "as prescribed" pain relief which was not documented as administered by staff.

From a review of stock control records in the centre, it was confirmed that these medicines had not been administered as the stock balance had not reduced during the period in question. The inspector also found that the stock balance did not match the administration records for one "as required" medicine for pain relief, and staff confirmed that this medicine had been administered the day before in line with the residents' prescription, but it had not been signed for on the drug recording sheet.

A number of residents were self-administering some of their medicinal products and had risk assessments in place; however, some of these documents were not fully completed at the time of the inspection. The level of support residents required was clear; however, some of the sections demonstrating how this decision was made were not fully completed.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Residents presented with complex behaviour support needs. They had interim behaviour support plans in place. These plans were found to be detailed and contained proactive and reactive strategies to use with residents where they were required. However, there was conflicting information in these plans in relation to the use of physical holds. For example, one section of the plan documented that holds were not to be used, while another referred to using techniques where trained to do so. From a review of incidents, two holds had been used. Therefore, inspectors were not suitably assured that there was clear guidance in relation to physical holds to ensure a safe and consistent approach was taken to implementing behaviour support plans.

Judgment: Substantially compliant

Regulation 8: Protection

Inspectors were not assured that the provider's systems for reviewing incidents in the centre were identifying safeguarding concerns and putting appropriate measures in place. For example, inspectors found four incidents between residents which had not been identified and therefore reported in line with national policy. Inspectors viewed safeguarding plans which had been put in place. However, it was unclear whether actions required on these plans were progressed. For example, three safeguarding plans indicated the need for all staff to ensure they followed positive behaviour support plans and that they were trained in positive behaviour support. However, this was not complete on the day of the inspection.
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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Rose Lodge OSV-0008576

Inspection ID: MON-0041257

Date of inspection: 17/10/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Maintain staff balance: Ensure optimal staffing levels with the right qualifications and skills to meet resident needs. • Recruitment policy: Follow Resilience Healthcare's recruitment procedures, conducting interviews and vetting in compliance with relevant legislation. • Qualification standards: minimum QQI level 5 qualification for support workers; providing support for assistant support workers to complete their QQI level 5. • Document compliance: all necessary information and documents specified in schedule two of the regulations for each employee. • Address staffing gaps: Based on three residents the wte requirement is 13.65wte. Rose Lodge currently has 9 wte permanent staff with 2wte Resilience Health care permanent relief staff. The remaining 2.65 vacancies are currently being filled by three regular agency staff until such time permanent staff are recruited to the service. • Continue to recruit: Proactively seeking to hire qualified staff to fill the 2.65 vacancies. • Replace nursing vacancies with suitably qualified support workers. • Updated SOPF to reflect the number qualifications and skill mix based on the assessed needs of the residents. There is now a planned and actual staff rota in place which includes the full names and position of all employees.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	

Prader Willi Syndrome Training:
Ensure team attendance at PWSAI-led training on 20th November 2023 to enhance understanding of Prader Willi Syndrome.

MAPA Training:
MAPA training confirmed for all Rose Lodge staff on 5th and 6th December, addressing crisis prevention and intervention. All staff in Rose Lodge will have MAPA training following this date.

First Aid Training:
Implement First Aid training sessions on 15th, 22nd, and 27th November, as well as 13th December

Positive Behavior Support Training:
Positive Behavior Support training on 22nd and 23rd November to enhance staff capabilities in managing positive behaviour outcomes.

Safe Administration of Medication Training:
Safe Administration of Medication training on 17th November to ensure staff competence in administering medications safely and accurately.

Hand Hygiene Training:
All staff will have completed hand hygiene training by 13th December

Infection Prevention & Contol Training:
All staff will have completed Infection Prevention and Control training by 13th December

Human Rights Training:
All staff will have completed Human Rights Training by 30th November

Ensure staff receive formal supervision every 8 weeks, as per Resilience Supervision Policy, to support, assess performance, identify training needs, recognise good practices, and address areas requiring improvement. Compliance with supervision is reported to the Director of Social Care on a monthly basis.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Resilience has 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.
The centre is supported by a PIC who is on site 2 days per week and is available to the Service Manager the days not on site, a full time Service Manager and a team of support workers. The PIC reports to the Director of Social Care.

Learnings from incidents are discussed at team meetings.

Rose Lodge has a risk register which is reviewed by the PIC, Service Manager and Resilience Clinical Risk Manager.

All potential safeguarding concerns are screened and discussed with the DO in line with organisational policy and legislative requirements.

Resilience HealthCare conducts an annual review of the quality and safety of care and support for the people we support and carries out at least one unannounced inspection in each residential service every six months. The reports and subsequent action plans for these visits are acted upon within each service and outcomes are monitored through Clinical Risk Manager function.

An annual quality review of the centre will take place in line with the regulations. This will include consultation with residents and/or their representatives.

Audit Schedule Maintenance:
Maintain a schedule of audits completed by the Person in Charge (Service Manager) to assess, evaluate, and improve care for service users and their living environment.

Quality Assurance Implementation:
The PIC will ensure all audits are up to date and correctly utilised in accordance with Resilience HealthCare Policies and procedures.

Weekly Validation and Action:
The PIC/Service Manager will ensure all audits, including risk reviews, are up to date and correctly utilised in accordance with Resilience HealthCare Policies and procedures.

Medication Audits:
The PIC/Service Manager will Implement weekly medication audits to ensure compliance with medication-related policies and procedures., in the short term to ensure proper oversight during the initial phase of the service, we've escalated our monthly medication audits to a weekly frequency.

The PIC/Service manager will ensure ongoing awareness among all employees regarding the designated liaison person by prominently displaying pictures and contact details in the designated centre and listing them at the front of the Safeguarding Policy.

Complaints officer is available to all employees/service users in the event that they want to raise a complaint outside their immediate line management.

Resilience HealthCare policies and procedures are to guide employee practice, ensuring consistency, quality, and efficiency in service delivery. Policies and Procedures will be discussed at Team Meetings to reinforce awareness and familiarity.
Protocols will be developed as required for specific challenges, offering clear step-by-step measures for staff ensure staff awareness of same.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The PIC is aware of their accountability to report any allegation, suspected or confirmed , of abuse of a resident. All notifications will be submitted in accordance with the time lines outlined in the regulations.

The PIC will conduct a weekly review of all incidents.

Training was held on the 3rd of November with all staff emphasing the prompt reporting of any allegation, suspected or confirmed, of abuse of any resident. Staff are aware of their responsibility to immediately report any concerns to their service manager and or the designated officer.

Four subsequent NF06 were submitted retrospectively by the PIC and safeguarding screenings were completed.

Safeguarding will remain an agenda item on team meetings and individual supervisions.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The PIC is completing a review of all risk assessments associated with Rose Lodge. A further review is in the process of being completed by the Head of Quality & Risk this will be completed by 21/12/2023

All issues that were identified with fire doors during the inspection have been resolved as outlined in the immediate action report. The fire doors are checked on a weekly basis as per our health and safety procedures. If the integrity of a fire door is compromised this is immediately reported to the Director of Property as a priority 1 and repair is arranged

as a matter of urgency.

Furthermore, established protocols offer explicit guidance and support for employees aiding residents during high-risk incidents. These protocols encompass escalation procedures to the service manager/PIC, the on-call system or emergency services.

Centre and service user risks are reviewed on a regular basis or as required by the PIC.

Prior to every team meeting, keyworkers will complete a summary template outlining the residents' month. This summary will encompass an overview of all incidents, facilitating a discussion focused on deriving insights and lessons from these occurrences.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All issues that were identified with fire doors during the inspection have been resolved as outlined in the immediate action report. The fire doors are checked on a weekly basis as per our health and safety procedures. If the integrity of a fire door is compromised this is immediately reported to the Director of Property as a priority 1 and repair is arranged as a matter of urgency.

A simulated nighttime fire drill took place on 19/10/23. Any issues arising from any fire drill risk assessments and PEEPS will be updated. Social stories will be completed if required to support residents to understand the risk of fire and fire drills.

Fire drills will be completed on a monthly basis to assess for any improvement in transitioning out of Rose lodge when the fire alarm goes off.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Medication audits have increased from monthly to weekly audits. This is to ensure there is full compliance with Resilience healthcare safe administration of medication policy and procedure. If there is a medication error/event this is reported on the incident management system.

All staff are trained in the safe administration of medication, no employee can administer

medication unless this training has been successfully completed.

All staff are completing a practical competency to assess their ability in medication administration. Further competencies for existing staff will be carried out as required. These competencies will be completed by 15/12/2023

Further training and support will be given to any staff member who requires it.

Self-administration assessments for service users have been reviewed and updated.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
All behavioural support plans have been reviewed and finalized. They are no longer in draft. Each behavioural support plan now has clear guidance on the use of physical holds. Behaviour support plans are reviewed regularly by the Behaviour Support Specialist.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All incidents are recorded on Resilience HealthCare incident management system. Incidents are reviewed by the Service Manager/PIC. The PIC is aware of their responsibility to submit notifications within the required time frame. Weekly audits of incidents will be completed to ensure that all notifications are submitted, and appropriate action taken.

All staff have completed safeguarding of vulnerable adult training and are aware of their responsibility to recognise, respond and report abuse. Refresher training will be arranged when required.

Safeguarding will remain on team meeting and supervision agendas.

All staff will have received MAPA and Positive Behavior support training by the 06/12/2023.

Upon receiving an allegation, staff are aware of their responsibility to promptly inform

the designated officer. Screening into the alleged events commences immediately. The PIC will submit statutory notifications within the required timeframe and assess if the incident is reportable to the Gardaí. Thorough screening into the alleged events is commenced to determine the presence of grounds for concern and potential abuse. If reasonable grounds are established, an investigation team will be appointed as per Resilience Healthcare's safeguarding vulnerable adults' policy to conduct a full inquiry into the alleged concerns.

All actions in safeguarding plans have been discussed with the team and all existing staff will have received MAPA training by the 31/12/2023.

Safeguarding plans will be developed and communicated to the staff team outlining actionable steps for resident protection. Progress on actions within the safeguarding plans will be documented for transparency and accountability.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/11/2023
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Not Compliant	Orange	30/11/2023
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in	Substantially Compliant	Yellow	30/11/2023

	circumstances where staff are employed on a less than full-time basis.			
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	17/11/2023
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.	Not Compliant	Orange	31/12/2023
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	17/12/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment,	Not Compliant	Orange	17/12/2023

	management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	20/10/2023
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Red	20/10/2023
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 ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and	Not Compliant	Orange	17/12/2023

	to no other resident.			
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	17/11/2023
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	31/12/2023
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	31/12/2023
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental	Substantially Compliant	Yellow	17/11/2023

	restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	17/11/2023