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:	Coolfin
Name of provider:	St Michael's House
Address of centre:	Dublin 9
Type of inspection:	Unannounced
Date of inspection:	24 October 2024
Centre ID:	OSV-0002375
Fieldwork ID:	MON-0045016

About the designated centre

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

Coolfin is a designated centre operated by St Michael's House. The centre provides residential care and support for up to six adults with intellectual disabilities. The designated centre comprises a detached two-storey house located in North County Dublin located near a large community park and within a short walking distance to nearby shops and public transport routes. The designated centre consists of six individual bedrooms for residents, two living room spaces, a kitchen and separate dining area and a staff office. St Michael's House operate a separate day service to the rear of the designated centre. The centre is managed by a full-time person in charge who is supported in their role by a nurse manager. The staff team comprises of nurses, social care workers, and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 24 October 2024	09:45hrs to 15:55hrs	Michael Muldowney	Lead
Thursday 24 October 2024	09:45hrs to 15:55hrs	Karen McLaughlin	Support

What residents told us and what inspectors observed

This unannounced inspection was carried out as part of the ongoing regulatory monitoring of the centre. The inspection focused on how residents were being safeguarded in the centre. Safeguarding is one of the most important responsibilities for a provider. Previous inspections of the centre had found that improvements were required to the safeguarding arrangements. Solicited information, by way of notifications throughout 2024 demonstrated that there were consistent and recurring safeguarding concerns relating to incompatibility of residents.

Inspectors used observations, conversations with residents and staff, and a review of documentation to form judgments on the quality and safety of care and support provided to residents in the centre. They found that residents received good care and support under some of the areas inspected. However, the incompatibility of some residents posed an ongoing risk to their safety and wellbeing, and the provider had not yet ensured that all residents were in receipt of services that was appropriate to their needs.

The centre comprised of a large two-storey house located in a busy suburb of Dublin. The house was close to many local amenities and services, including shops, parks, cafés, and public transport. The house was bright, warm, clean, comfortable, homely, and nicely decorated. Each resident had their own bedroom, and the communal spaces included two sitting rooms, a dining room, and a kitchen. A notice board in the hallway displayed information on advocacy services, safeguarding, and the complaints procedure. There was also nice pictures and photos of residents displayed in the centre.

There were five residents living in the centre with one vacancy. The provider did not plan to fill this vacancy until the current incompatibility issues were resolved. The residents had varied support needs. On the day of the inspection, some residents attended day services, while others relaxed in the centre which was in line with their will and preferences.

One resident did not verbally communicate with inspectors. Two residents briefly spoke with inspectors when they returned from their day services. They said that they enjoyed their service and had participated in activities including swimming and a painting class. Another resident was retired, and invited inspectors to see their bedroom and speak with them. Their bedroom was cosy, comfortable, and personalised to their tastes. They showed inspectors their mobility equipment, personal items, and framed photos. They also spoke about their favourite programmes.

The provider and person in charge had implemented good systems for residents' voices to be heard. For example, residents attended house meetings, planned personal goals, were consulted with as part of the annual review, and were supported to make complaints. Inspectors viewed a sample of this documentation,

including complaints made by residents in relation to the behaviours displayed by other residents. These matters are discussed further in the report.

The provider’s recent annual review of the centre, dated October 2024, had consulted with residents. They provided some positive feedback. For example, they liked their bedrooms and spoke about their favourite activities. However, they also raised concerns about living in the centre, such as the aggressive behaviour displayed by other residents.

Residents' representatives had provided feedback as part of the annual review for the centre. Their feedback was very complimentary of the staff and management team but some family representatives had made complaints in relation to the ongoing incompatibility of residents and concerns in relation to this.

Inspectors met and spoke with staff during the inspection, including the person in charge, clinical nurse manager, and social care workers. Inspectors observed staff engaging with residents in a supportive and caring manner, and there was a warm rapport between them. Staff also spoke about residents in a very respectful and kind manner, and it was clear that they knew the residents well, and were striving to provide them with a safe, quality, and person-centred service.

However, all staff spoken with expressed concerns about the ongoing incidents which were impacting residents' safety and wellbeing. They told inspectors that the incidents were recurring, and the extensive strategies in place were not effective in reducing the incidents. They said that residents were being negatively impacted, and in some instances were being upset and frightened to the point of crying. Staff were concerned that the incidents were escalating and may result in more serious harm to residents. Staff were aware of the safeguarding policies and associated plans and were implementing them to the best of their ability.

The management team, including the clinical nurse manager, person in charge and Director of Service, spoke about their concerns for residents safety and wellbeing in the centre. They told inspectors about the provider's plans to resolve the incompatibility issues by supporting the transition of a resident to a more appropriate setting that would better meet their needs. This is discussed further in the next section of the report.

Many aspects of the service provided to residents were to a high standard, and while the provider and person in charge had made extensive efforts to ensure that residents were safe from potential abuse in the centre, their efforts were not effective. The incompatibility of residents and associated safeguarding concerns which presented in 2022 had not been resolved, and this meant that residents were living in a centre that did not protect them from potential and actual abuse.

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

Capacity and capability

Generally, the provider had ensured that the centre was well resourced. For example, sufficient staffing resources were in place. However, the arrangements to ensure that residents' needs were being fully met in the centre required improvement. Additionally, while there were management and oversight systems in place to support the delivery of a service that was safe and appropriate. The provider's arrangements for completing annual reviews required improvement, and their efforts to resolve known safeguarding risks due to incompatibility issues were not successful. The Director of Services told inspectors about the provider's challenges in finding resources and and suitable services for all residents to live in. They had approved a review of their services to look at potential compatibility issues and to inform an associated future plan.

The management structure in the centre was clearly defined with associated responsibilities and lines of authority. The person in charge was full-time and supported in the management of the centre by a nurse manager. The person in charge managed two designated centres. The person in charge reported to a service manager and Director, and there were effective systems for the management team to communicate and escalate any issues.

The registered provider had implemented management systems to monitor the quality and safety of service provided to residents, for example, annual reviews, six-monthly reports, and a suite of other audits were carried out. However, the most recent annual review, dated October 2024, was overdue by six months. The management team monitored actions identified from audits.

The staff skill-mix in the centre comprised nurses, social care workers and care assistants. The skill-mix and complement was appropriate to the needs of the residents, and staff leave was covered by regular relief staff to support residents' continuity of care. The person in charge maintained planned and actual rotas showing staff working in the centre.

Staff completed relevant training as part of their professional development and to support them in their delivery of appropriate care and support to residents. The person in charge provided quality support and formal supervision to staff working in the centre. Staff also attended regular team meetings which provided an opportunity for them to any raise concerns regarding the quality and safety of care provided to residents. Inspectors viewed a sample of the recent staff team meetings from August and September 2024, which reflected discussions on safeguarding, fire safety, risk, incidents, training, audits, residents' updates and personal goals, and infection prevention and control.

Regulation 15: Staffing

The staff skill-mix in the centre consisted of nurses, social care workers and care assistants which the provider had determined was appropriate to the number and needs of the residents. The provider had provided additional staffing resources as a measure to reduce the safeguarding concerns in the centre. The person in charge told inspectors that the complement and skill-mix was sufficient.

The person in charge maintained planned and actual rotas that showed staff on duty during the day and night in the centre. The inspectors viewed the September, October, November 2024 rotas. Staff leave was primarily filled by regular relief staff to promote consistency of care for residents.

Inspectors found that staff spoken with had a good understanding of residents' individual personalities and needs, and supported them in a kind and respectful manner.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to appropriate training as part of their professional development and to support them in delivering effective care and support to residents. Staff completed a suite of training as part of the systems to safeguard residents and promote their rights in the centre. The training included, safeguarding of residents from abuse, positive behaviour support, human rights, and management of challenging behaviour (some staff were overdue refresher training, and this matter is discussed under regulation 7).

The person in charge provided effective support and formal supervision to staff. Informal support was provided on an ongoing basis and formal supervision was carried out in line with the provider's policy. In the absence of the person in charge, staff could contact the service manager or on-call system for support and guidance.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the centre with associated lines of authority and responsibility. The person in charge was full-time, and demonstrated effective oversight and management of the centre. They were supported in their role by a nurse manager, and reported to a service manager who in turn reported to a Director. There were good arrangements such as regular meetings and sharing of governance reports for the management team to

communicate and escalate issues.

There were management systems to ensure that the quality and safety of the service provided to residents was monitored, such as audits and unannounced visit reports. The provider's most recent annual review had consulted with residents and their representatives. However, it was overdue by six months due to an oversight. The management team had good oversight of the risks presenting in the centre such as the safeguarding concerns, and were endeavouring to resolve them.

However, the provider had not ensured that the service provided in the centre was safe and appropriate to residents' needs. This is demonstrated through the ongoing incompatibility issues and safeguarding concerns that date back to 2022. While the provider had made extensive efforts to address these matters including plans to transition one resident, the efforts so far have not been fully effective.

There were effective arrangements for staff to raise concerns. In addition to the staff supervision and support arrangements, staff also attended regular team meetings which provided an opportunity for them to raise any concerns about the quality and safety of care and support provided to residents.

The arrangements for inducting relief staff required improvement to ensure that all relief were adequately informed on their duties in the centre and of pertinent information. Of the four regular relief staff working in the centre, induction records were only maintained for two. Therefore, it could not be verified if all relief staff had received a sufficient induction on the centre.

Judgment: Substantially compliant

Quality and safety

This inspection found there were many aspects of residents' wellbeing and welfare that were being upheld by a good standard of evidence-based care and support. However, not all residents' assessed needs were being met in the centre and and this was having an adverse impact on the quality and safety of service provided to them and their peers and resulting in ongoing and protracted incompatibility issues that were contributing to safeguarding concerns.

The person in charge had ensured that assessments of most residents' needs were completed which informed the development of personal plans. The inspector reviewed a sample of residents' assessments and plans. One resident required an up-to-date communication assessment and care plan from an appropriate healthcare professional to ensure that they were adequately supported to communicate. Additionally, the recording of updates to residents' personal goals required improvement to demonstrate how they were being supported to progress their goals. Some residents were assessed as requiring alternative living arrangements to benefit them and other residents. While the provider was endeavouring to source

suitable accommodation, these unmet needs presented ongoing and serious incompatibility and safeguarding risks between residents.

The provider had good arrangements for managing safeguarding concerns such as staff training, and development of safeguarding plans. However, the risk to residents' safety had not been mitigated, and residents remained at risk of harm from other residents in the centre.

The person in charge had ensured that written personal care plans had been prepared to guide staff in supporting residents in this area in a manner that respected their dignity and bodily integrity.

Where required, positive behaviour support plans were developed for residents, and staff were required to complete training to support them in helping residents to manage their behaviours of concern. However, inspectors were told and read that the plans were not fully effective, and not all staff had received training in the management of challenging behaviour which posed a risk to how they responded to behaviours of concerns.

There were some restrictive practices in the centre. The rationale for the restrictions was clear, and the provider had prepared a written policy to govern their use.

Regulation 10: Communication

Inspectors found that one resident required an up-to-date communication assessment and plan that was informed by an appropriate professional to ensure that the resident's communication needs were clearly identified and appropriate supports were in place. This requirement had already been identified by the person in charge in August 2024, but remained outstanding.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had prepared and implemented a written risk management policy, reviewed in June 2023, which outlined the arrangements for identifying hazards and carrying out risk assessments.

Inspectors viewed the a sample of the risk assessments pertaining to the centre, including those on behaviours of concern, slips and falls, infection prevention and control, and choking risks. The risk assessments had been primarily completed by the person in charge, and the inspectors found that they outlined control measures for implementation in the centre. The provider's health and safety department had also recently visited the centre to review the risk management systems and provide

guidance.

Overall, the inspector found that the arrangements for identifying and managing risks in the centre were appropriate (however, as noted under regulation 7 and 8 the control measures to support residents to manage behaviours of concern and to mitigate safeguarding incidents were limited in effectiveness).

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider had not ensured that the appropriate arrangements were in place to meet the needs of each resident. They had identified that the centre was not fully suitable to meet all residents' assessed needs, particularly in relation to the required living arrangements for one resident and their incompatibility with other residents which was resulting in ongoing safeguarding concerns. They planned to support one resident to transition to a more suitable premises. However, there was no confirmed time-frame for this move.

The person in charge had ensured assessments of residents' needs were completed which informed the development of personal plans. Inspectors reviewed a sample of residents' assessments and plans. The plans, included those on personal, health, and social care needs. The documentation reflected input from various health and social care professionals, including psychology, nursing, physiotherapy, occupational therapy, and speech and language therapy. As noted under regulation 10, one resident was awaiting a communication assessment, and as noted under regulation 7, behaviour support plans required better organisation to ensure that staff were implementing the most up-to-date versions.

Residents were also supported to plan social goals such as going on holidays and to concerts. Inspectors found the associated documentation required improvement to better demonstrate their progress. For example, one resident had a goal to go to a foreign theme park, but the progress reviews had been last updated in March 2024. This finding was also found during the January 2024 inspection, however had not been addressed.

The recording of important information also required more consideration. Inspectors read in a resident's assessment that a resident's representatives had concerns about the incompatibility issues in the centre, however details of the concern were not recorded.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The registered provider and person in charge had implemented measures to support residents to manage their behaviours. However, these measures were not fully effective.

Staff were required to completed positive behaviour support training and management of challenging behaviour training. However, training records showed that some permanent staff required refresher training in management of challenging behaviour, and four relief staff also required in-person training. This gap in training posed a risk to effectiveness of the care and support by staff, particularly as incidents of aggression were a regular occurrence in the centre.

Positive behaviour support plans were in place. However, inspectors read and were told that the plans were not fully effective, and in recent times the strategies were not working. This posed a risk to residents' safety and wellbeing. Additionally, inspectors found that some residents' files did not contain the most up-to-date version of their behaviour support plans which impinged on the purpose of the plans. The person in charge ensured that this matter was addressed before the inspection concluded.

Inspectors also found that the recording of behaviours and the implementation of strategies required improvement to provide better quality data for review. For example, daily behaviour recording sheets were completed by staff for one resident. The inspectors viewed the September and October sheets, and found that they were completed every day, and would benefit from more data fields such as the time incidents occurred. Staff also told inspectors that strategies such as use of social stories were not always effective. However, it was not recorded when the social stories were tried and how the resident engaged.

Judgment: Not compliant

Regulation 8: Protection

Safeguarding concerns had been reported, responded to, and managed in line with the provider's policy. However, there was ongoing safeguarding concerns and incidents, including physical aggression, verbal and psychological abuse, and allegations of sexual abuse, attributable to the incompatibility of residents. Concerns for residents’ safety were noted in the provider’s internal audits and annual review, management meeting minutes, assessments, safeguarding plans, and complaints made by residents and their families.

Safeguarding plans had been developed outlining the interventions to keep residents safe from abuse. However, staff spoke about the limited effectiveness of the safeguarding plans, and the challenges they faced in ensuring residents’ safety. This was also noted in associated safeguarding plans. Inspectors were told by staff and read documentation about how residents quality of life in the centre was being

adversely impacted due to the recurring safeguarding incidents. Safeguarding documentation noted that residents are living in fear and sometimes cry after incidents, and staff and residents' representatives were concerned that residents could be seriously injured. Staff told inspectors that incidents were happening on a daily basis, and residents were frightened, intimidated, and withdrawn at times.

Judgment: Not compliant

Regulation 9: Residents' rights

The provider, person in charge, and staff team had implemented systems to ensure that residents' rights were promoted and upheld in the centre. For example, staff were undertaking human rights training to inform their practices, the provider had implemented a complaints procedure that was accessible to residents, and residents were consulted with about the running of the centre and on their care and support needs.

Residents attended regular house meetings. Inspectors viewed a sample of the meeting minutes from July to October 2024. The minutes noted a range of topics discussed, including complaints, safeguarding, fire safety, road safety, infection prevention and control, menus, activities, the residents' guide, independent advocacy services, and reminders to be "nice to each other".

However, residents' rights were being impacted by the ongoing incompatibility issues. Some residents had expressed a wish to move out, and this had not been achieved yet to ensure that their needs were being met. Inspectors also viewed complaints from residents and their family members about their experiences in the centre. For example, complaints included that residents were being verbally and physically harassed, and that they were frightened. These complaints remained open.

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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Coolfin OSV-0002375

Inspection ID: MON-0045016

Date of inspection: 24/10/2024

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

- Going forward annual reviews will be completed within required timeframe.
- The Provider will continue to escalate the risk identified within the centre at HSE IMR meetings untie the compatibility issues within the centre are resolved.
- The Provider will continue to raise the risks within the centre with HSE local safeguarding team. Further reviews to be scheduled by the Provider by 01.03.2025.
- Regular clinical input and ICMs will continue until the compatibility issues within the centre are resolved.
- The PIC has reviewed the induction process and ensures that all staff will receive a full induction into the centre, to include all guidelines and supports. Records are now held within the centre
- In an effort to mitigate against further safeguarding issues and in agreement with all residents within the centre. In 2025, the Provider will continue to provide extra nights away from the centre for one resident. Since September 2024 the resident has had 15 approx. nights away from the centre, which has seen a notable reduction in NF06/PSF1 to 7 in the last quarter down from 17 in the previous quarter. More dates booked from now up to April 2025.
- Ongoing compatibility meetings will remain in place until the compatibility issues within the centre are resolved.
- Referral to psychologist sent for all residents 8.11.2024. Review of 4 residents individual needs associated with the compatibility concern completed 22.11.2024 and updates to PBS and/or other support plans made as required. One resident and their PBS will be reviewed by psychologist on 17.12.2024 and PBS updates completed by 10.01.2025.
- Director of Adult Services (DOAS)has engaged with the Principal Psychologist for Adult Services in relation to commissioning a Multi-Element Plan (MEP) for the resident to ensure appropriate suitability of future placement options; a decision to progress the MEP will be agreed by 31.12.2024.

• To prepare for the MEP and plan future placement needs the following referrals and assessments have been completed:
- Physio referral submitted 8.11.2024- Assessment completed 03.12.2024
- OT referral 12.11.2024 – Assessment completed 03.12.2024
- SLT referral 08.11.2024- assessment began 25.11.2024 to be concluded in January 2025.

Placement Option 1: Apartment
• PIC & Service Manager visited and reviewed the apartment (currently rented by the provider) on 4.11.2024.
• The Provider's Fire Officer reviewed the apartment 15.11.2024 and completed an environment and fire review.
• The Chief Assistant Technical Services officer reviewed the apartment on the 25.11.2024 with report and costings for works completed 04.12.2024.
• OT and Physio reviewed apartment to assess it suitability for the needs of the resident and a report was issued on 03.12.2024.
• Roster review for new centre completed 29.11.2025
• Business case will be completed and submitted to the HSE 03.01.2025.
•

Placement Option 2: Centre Conversion
• Chief Assistant Technical Services officer and architect has completed a site visit to an existing residential centre and completed a preliminary report, in relation to possible conversion of the centre in meeting the needs of all the residents.
• Architect Plans of proposed works have been completed.
• Costings of plans have been completed.
• Business case was completed by the DOAS on 29.11.2024 seeking funding approval to meet the assessed needs of the identified resident.
• DOAS will seek update on business case outcome by 24.01.2025

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:

SLT referral for one resident sent 08.11.2024. The assessment to identify the residents' communications needs began on 25.11.2024 and will continue in January 2025 with identified supported implemented where identified.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• PIC to complete review of goal trackers by 31.01.2025 and agree all timelines for completion with keyworkers by 14.02.2025.
• The PIC is planning and sourcing quotes for a resident's holiday – holiday will be booked by 31.01.2025 for second quarter of 2025.
• One resident will be reviewed by psychologist on 17.12.2024 with required updates

completed by 10.01.2025.
• Following an OT, SLT and Physio assessment for one, the relevant support plans will be reviewed by 31.01.2025, based on these assessments.
• PBS is now stored in active folder and attached to a support plan; a copy is also in daily folder for both residents.

Regulation 7: Positive behavioural support	Not Compliant

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

• Full PBS training dates booked for 22.01.2025, 20.02.2025, 10.04.2925 for required staff.
• 8 permanent staff and 4 relief staff will receive their TIPs training by 31.03.2025
• Referral to psychologist sent for all residents 8.11.2024. review completed 22.11.2024 for 4 residents individual needs associated with the compatibility concern and updates to PBS and/or other support plans made as required. One resident will be reviewed by psychologist 17.12.2024 and with required updates completed 10.01.2025.
• Psychologist to attend next staff meeting on 17.12.2024 to review current strategies and their effectiveness and update accordingly.
• PBS guidelines: now stored in active folder attached to a support plan and a copy is in daily folder for both residents. All permanent staff and relief and agency have reviewed and signed PBS.
• Recording of behaviors sheet to be reviewed by the psychologist with the team on 17.12.2024 and further data fields to be added were required.
• Recording the usage of social stories will be discussed at team meeting on 17.12.2024 and an agreed system implemented to ensure the use of social stories is recorded.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• PIC and Service manager to review all risk assessments on 18.12.2024 regarding the compatibility issue in the centre and update where required.
• The Provider will continue to provide extra nights away for one resident with dates booked up to April 2025.
• Following an incident, residents will continue to be reassured and offered 1:1 support and/or clinical support where required.
• The Provider will continue to complete safeguarding audits within the centre
• Ongoing compatibility meetings will remain in place until the compatibility issues within the centre are resolved. Next meeting scheduled 27.02.2025
• The Provider is also in the process of completing a compatibility review across the entire organisation to identify collective funding to support with compatibility. Report is in draft format and will be completed 31.01.2025 to present to HSE

Regulation 9: Residents' rights	Substantially Compliant

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

- One resident has expressed a wish to move out and has undergone four residential consultations within the service and the provider is currently reviewing two placement options.
- PIC and Service manager to review open complaints on 18.12.2025 and agree and progress escalations in line with the providers Complaints policy by 31.01.2025.
- Business case was completed by the Director of Adult services on 29.11.2024 seeking funding approval in meeting the assessed needs of the identified resident

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	30/03/2025
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	30/03/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with	Substantially Compliant	Yellow	31/05/2025

	the statement of purpose.			
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	31/05/2025
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	27/11/2024
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/03/2025
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in	Not Compliant	Orange	31/05/2025

	accordance with paragraph (1).			
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	31/05/2025
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.	Not Compliant	Orange	30/03/2025
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	30/03/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/05/2025
Regulation 09(3)	The registered	Substantially	Yellow	31/05/2025

	provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Compliant		