Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Cliff House
Name of provider:	Stepping Stones Residential Care Limited
Address of centre:	Dublin 3
Type of inspection:	Announced
Date of inspection:	11 June 2024
Centre ID:	OSV-0003257
Fieldwork ID:	MON-0035150

About the designated centre

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

The designated centre consists of two houses with the capacity to provide full-time residential care and support for four children with an intellectual disability and autistic spectrum disorder. Residents are supported with their positive behaviour support needs, augmentative communication needs, emotional support needs, and physical and intimate care support needs. The centre is situated in a suburban area of Dublin with access to a variety of local amenities such as shops, train stations, bus routes, churches and the city centre. There are vehicles available to enable residents to access school and local amenities. There are two premises in the designated centre. The first house is a three-bedroom, split level, terraced home. The second house is a two bedroom, terraced split level house over three stories, situated within walking distance of the other house. Each resident has their own bedroom all of which are single en-suite rooms. Each resident is actively encouraged to personalise their own bedroom. Residents in the centre are supported 24 hours a day, seven days a week by a staff team comprising of a person in charge, person participating in the management of the centre, and healthcare workers. Staffing numbers are adjusted as the dependencies of the residents change.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 11 June 2024	09:45hrs to 18:30hrs	Karena Butler	Lead

What residents told us and what inspectors observed

Overall, on the day of the inspection, the inspection findings were positive. Residents were observed to be happy and content in their home, they enjoyed a good quality of life and their individual choices and decisions were being supported and encouraged by the person in charge and the staff team.

However, some areas were identified for improvement. They included, positive behavioural support, communication, training and staff development, fire precautions, and medicines and pharmaceutical services. These areas will be discussed in more detail later in the report.

The centre was made up of two houses within a few minutes walk of each other. The inspector had the opportunity to meet the four residents that were living in the centre. During the course of the inspection, three residents attended school and then returned later in the day. One resident was availing of home tuition.

On the evening of the inspection residents activities varied. One resident went on a family visit supported by staff, another relaxed in the centre as per their choice and another went for a drive followed by going to a shopping centre as that resident loved to walk around shops. The resident that was living in house two came for a visit to house one after school. They relaxed in the kitchen and had a snack.

Over the course of the inspection, the inspector observed staff members on duty and the person in charge to use relaxed, respectful and on occasion jovial communication when speaking with the residents. For example, two staff members were observed playfully teasing a resident to encourage them to spend time in the garden. The resident clearly enjoyed the interaction as they were observed smiling on different occasions.

Staff were observed to advocate on behalf of the residents. For example, when the inspector asked to meet with a particular resident a staff member explained that they were relaxing in their room and did not want to be disturbed. They explained that they would inform the inspector when the resident was comfortable meeting with them.

Residents were observed to appear very relaxed and comfortable in their home and in the presence of staff. For example, residents moved freely around each of their houses, going to their rooms and using their kitchen.

The provider had arranged for staff to have training in human rights. One staff member spoken with said that they felt the training gave them an emphasis on developing independence with regard to developing life skills. Also that it was the residents' right to have choice in what they wanted. They discussed the importance of taking a step back and not to force issues. They gave the example of the resident that was being supported to re-engage in going outside of the centre. They said that

they try not to force the issue as it is the resident's right to not leave and that instead they try to take a more encouraging role. They said that they now leave the front door open for periods and leave items that may be of interest to the resident outside in the garden to entice them outside. They communicated that it was the resident's decision whether they wished to go outside or not.

The inspector observed the houses to be very tidy. Each resident had their own bedroom and there was adequate storage facilities for personal belongings. They were individually decorated to suit the preferences of each resident. For example, one resident had wall stickers decorating their bedroom walls.

There was a front and back garden accessible to the residents in one house and a back garden accessible in the second house. There was a trampoline available in the gardens of both houses.

The inspector also had the opportunity to speak to one family representative when they came to visit their family member. They communicated that they were happy with the service and that they had no concerns. They said they knew how to raise a concern or complaint if they needed to. They were happy with the staff team and communicated that in their opinion their family member appeared comfortable living in the centre.

The provider had sought residents' and family representatives' views on the service provided by way of the six monthly unannounced visits. Communication received from family representatives demonstrated that people were very happy with the service. For example, one family representative communicated that their family member was happy and well supported by the person in charge and the staff. Another said that, staff should be 'very proud of what they were doing'.

As part of this inspection process residents' views were sought through questionnaires provided by the Health Information and Quality Authority (HIQA). Feedback from the questionnaires was returned by two family representatives on behalf of the residents and they were positive in their responses. One representative listed some of the activities that their family member attended and said that activities were up to the resident whether they wanted to participate.

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

Capacity and capability

This inspection was announced and was undertaken following the provider's application to renew the registration of the centre. This centre was last inspected in September 2022. Any actions from the previous inspection had been completed by

the time of this inspection.

There were effective management arrangements in place that ensured the safety and quality of the service was consistent and closely monitored. For example, there was a full-time person in charge and the provider completed six monthly unannounced visits to the centre to assess compliance levels.

There were systems in place to monitor and facilitate staff training and development. For example, staff were receiving formal supervision and had access to training, such as medication management. However, some improvements were required with regard to staff competency assessments and some training made available to staff.

The inspector reviewed a sample of rosters and they indicated that there were sufficient staff on duty to meet the needs of the residents.

From a review of a sample of two residents' transition plans to another centre, the inspector noted that, the residents were observed to be involved in the move. Additionally, from a sample of two contracts of care reviewed, the inspector saw that the services provided and fees to be charged were included in the document as required by regulations.

The provider had suitable arrangements in place for the management of complaints. For example, there was an organisational complaints policy in place.

Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced to fulfil the requirements of the role. They were a qualified social care professional and they were employed in a full-time capacity within this centre. They demonstrated that they were familiar with the residents' care and support needs. For example, they discussed the support strategies that one resident required around their anxiety.

A staff member spoken with communicated that they would feel comfortable going to the person in charge if they were to have any issues or concerns and they felt they would be listened to.

Judgment: Compliant

Regulation 15: Staffing

A sample of rosters were reviewed over a four month period from March to June 2024. They demonstrated that there was sufficient staff in place at the time of the inspection to meet the needs of the residents. There was a planned and actual

roster in place maintained by the person in charge.

The provider was in the process of revising their staffing arrangements within the centre based on residents' assessed needs. As a result of that staffing review, the inspector observed a very recent reduction in staff allocated specifically to different residents. The inspector saw minutes of a meeting conducted between the person in charge, a family member and a behaviour therapist where it was agreed that a trial in the reduction of staffing levels assigned for some residents would be commenced. The person in charge assured the inspector that staffing levels were being kept under review to assess the impact of the reduction and to ensure they continued to meet the assessed needs of the residents.

On the day of inspection, there was a full complement of staff in place which ensured continuity of care and support to residents.

From speaking with one staff member and the person in charge, the inspector found that they were familiar with the residents' care and support needs. The residents appeared comfortable in their company, for example a resident was observed making their needs known to staff by taking a staff member by the hand to the drinks press in order to get a drink. Staff were then observed offering the resident a choice of drink and coloured cup.

Judgment: Compliant

Regulation 16: Training and staff development

From a review of the training matrix and a sample of training certification, staff for the most part received training in order for them to carry out their roles effectively. For example, staff were trained in areas, such as fire safety, first aid, medicines management, and positive behaviour support.

Staff had received additional training to support residents, for example staff had received training in human rights. Further details on this have been included in 'what residents told us and what inspectors observed' section of the report.

The centre management completed what they called 'check and challenge' checks with staff members once or twice a year. This was where staffs' knowledge was assessed on different topics to provide assurance to the provider that, staff had the knowledge and skills to effectively and safely provide care to the residents. Topics covered included, medicines management, infection prevention and control (IPC) and safeguarding.

However, staff had not received training in respiratory hygiene and cough etiquette. In addition, they had not received training in transmission-based precautions (contact, droplet and airborne), including the appropriate use of personal protective equipment (PPE) for each situation as per public health guidance. Additionally, staff did not have training provided in the area of Autism. Due to the assessed needs of

the residents, that training would provide staff with additional knowledge to more effectively support the residents.

Staff were receiving competency assessments in areas such as medicines management from the person in charge or team leaders. However, the person in charge or the team leaders did not have any additional training to provide them with the knowledge or expertise to carry out these assessments. This was required in order to assure the provider that they were appropriately trained in order to sign staff off as competent in that area.

The inspector also reviewed supervision files for three staff working across the two houses that made up this centre. The files demonstrated that, supervision arrangements which facilitated staff development were occurring in line with the provider's policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that there were suitable governance and management systems in place. There was a defined management structure in the centre which consisted of a person in charge and the senior manager, who was the person participating in management for the centre.

The provider had arrangements for unannounced visits and an annual review of the service to be completed as per the regulations.

The inspector observed there was a schedule of audits in place for 2024 in order to assess the quality and safety of care and support provided to residents in the centre. An example of areas included were, medicines, IPC, and environmental audits which included fire safety and general health and safety. This was to ensure that any identified issues would be rectified or escalated within in a timely manner.

The inspector reviewed team meetings carried out since January 2024, and found that for the most part meetings were taking place monthly and incidents were reviewed for shared learning with the staff team.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

The inspector reviewed the arrangements for residents to transition to other centres when applicable. Residents were supported in moving to other centres or to this centre through an individual transition plan. The inspector reviewed the transition

plans for two residents that were due to move from the centre in the coming weeks or months. Residents and their representatives were given opportunities to visit the proposed new house. The inspector observed social stories that were completed for the residents to help support their understanding of what was happening or due to happen.

The inspector also reviewed a sample of two residents' contracts of care. They laid out the services and conditions of their service and fees to be charged to the resident and they were signed.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had adequate arrangements in place for the management of complaints. There was a complaints policy, and associated procedures in place. An accessible version of the policy was available for residents, and a the poster of the nominated complaints officer poster was displayed in a prominent position. Any complaints made had been suitably reviewed, resolved and they were documented. As previous stated, a family member spoken with was aware how to make a complaint if required.

Judgment: Compliant

Quality and safety

Overall, the inspection found that the residents were receiving a good standard of care that promoted and respected their independence, views and wishes. However, as previously stated some improvements were required in relation to positive behavioural support, communication, fire precautions, and medicines and pharmaceutical services.

While communication was being supported in the centre, further improvement was required to ensure staff were adequately guided to residents support requirements which would in turn facilitate residents to communicate effectively.

For the most part, there were suitable fire safety management systems in place, which were kept under ongoing review. However, more assurance and further enhancements were required to the fire detection and alert system coverage to ensure it was appropriate for the centre. In addition, some improvement was required to the accuracy of the personal emergency evaluation plans (PEEP) and fire drills, so as to ensure all residents could be evacuated to safety using minimum staffing levels. Furthermore, one room used by staff on occasion as a bedroom was

not suitable for used as such, as it was an inner room. This did not provide for safe egress in the event of a fire.

From a review of medicines management, the inspector observed that for the most part there were suitable arrangements in place. However, improvement was required for more thorough stock control checks of medicines received into the centre.

The inspector reviewed restrictive practices in use in the centre, for example some doors or presses were kept locked, such as the chemical press. They were assessed as necessary for the safety of the residents and subject to review. Residents were being supported with their emotional needs. However, some residents' positive behaviour support plans required review to ensure all information was up to date.

Residents healthcare needs were known to staff and they had access to allied health professionals as required. For example, residents had access to their general practitioner (GP) when required. Additionally, residents were supported to have meaningful days in line with their personal preferences.

From a review of the safeguarding arrangements in place, the provider had arrangements to protect residents from the risk of abuse, for example staff had received training in child safeguarding.

The inspector observed the premises was tidy and for the most part clean and in a good state of repair. Any identified areas for cleaning were rectified on the day of the inspection.

There were systems were in place to manage and mitigate risk and keep residents safe in the centre. For example, there was an organisational risk management policy in place.

Regulation 10: Communication

From a review of two residents' files, the inspector observed that there was some documented information in residents' personal plans on their communication styles and how best to communicate with them. However, the plans did not elaborate on the sign language signs one resident may use and understand. Therefore, they did not guide staff to adequately communicate with them.

In addition, the inspector observed that another resident's plan did not adequately guide staff on the use of a picture exchange system that some of the residents in the centre used. Staff were found not to be trained in the use of this system. Therefore, the inspector was not assured that the children's communication needs were being appropriately addressed. This meant that the communication needs were, potentially, not familiar to all staff, to ensure that the children could communicate appropriately. Notwithstanding, from speaking with the person in charge and two staff, they were familiar with how best to communicate with the

residents.

There were picture boards displayed in the centre to facilitate communication and the inspector observed on occasion staff using the pictures to communicate with a resident. However, the picture meal planner displayed in the kitchen was not updated to reflect a change in the meal for the night of the inspection. From speaking with a staff member, it was not evident that the children were involved in the decision to change the meal and it was not evident that the change was communicated to them.

The person in charge communicated that some of the children received input from a speech and language therapist (SALT) in their schools. However, no formal assessments were completed and there were no official recommendations recorded from the therapist to guide staff. Information was provided to the person in charge informally. This had the potential that pertinent information from the therapist could be missed or implemented incorrectly.

The inspector observed that the residents had access to televisions, phones and Internet within the centre.

Judgment: Substantially compliant

Regulation 13: General welfare and development

Residents were supported to attend school or participate in a home tuition programme with oversight from a school principle.

Residents were supported to develop independence and life skills, For example, from a review of two residents' goals, they ranged from learning to tie shoe laces to becoming comfortable sitting at the table to eat their dinner instead of their room. The inspector observed progress notes to evaluate how goals were progressing.

The inspector reviewed the logs of activities that two residents participated in during May 2024. From the sample reviewed, residents were observed to participate in activities based on their interests, for example attending a fitness class, going to a theme park, baking and water play. Another resident was being supported to re-engage in the community after a period of them being reluctant to leave the centre. The person in charge communicated to the inspector that there were plans to further develop and expand on the activities and experiences that the residents participated in.

Residents were encouraged and facilitated to keep in contact with their family through visits. For example, one resident was supported to go on weekly visits to their family home.

Judgment: Compliant

Regulation 17: Premises

The premises was observed to be tidy and for the most part clean. The house was observed to be well maintained on the day of this inspection. There was adequate space for the residents, for example there were multiple communal areas. Each resident had their own bedroom. They were decorated in line with the residents' preferences. For example, one resident had wall stickers displayed on the walls of different parts of their room.

Residents had access to cooking and laundry facilities. Residents were encouraged to make use of the kitchen to help prepare some of their meals and get snacks and drinks for themselves.

The inspector observed that some areas required further cleaning, for example there was some mildew observed in different shower enclosures. The person in charge arranged for any additional identified cleaning requirements to be cleaned on the day of the inspection and the evidence shown to the inspector. In addition, they assured the inspector that observations for mildew would be added to an environmental checklist to ensure timely removal in the future.

Judgment: Compliant

Regulation 26: Risk management procedures

There were adequate systems in place to manage and mitigate risk and keep residents safe in the centre. For example, there was a policy on risk management available that was reviewed in May 2024.

A risk register was maintained for the designated centre which was reflective of the presenting risks. There were risk assessments completed for identified risks, for example:

- infection prevention and control with regard to infectious illnesses
- fire safety
- behaviours of concern
- residents going missing while in care.

Risks specific to individuals, such as choking had also been assessed and control measures identified.

The inspector reviewed a sample of the incidents that occurred in the centre since January 2024. They were found for the most part to be suitably recorded, escalated

if required and responded to with the exception of a recent medication incident. This is being dealt with under Regulation: Medicines and pharmaceutical services. Learning from incidents was shared with the staff team were appropriate.

On review of other arrangements in place to meet the requirements of this regulation, the inspector observed that the oil boiler had received an annual service.

Judgment: Compliant

Regulation 28: Fire precautions

For the most part, there were suitable fire safety management systems in place, including detection and alert systems, fire containment doors, emergency lighting and firefighting equipment, each of which was regularly serviced.

While there was a fire alarm detection system present in the centre, the type of alarm and cover that was provided by the alarm was not available on the day of the inspection. Subsequent to the inspection, the provider consulted with an external professional in the area of fire and they submitted the information requested. The response did not provide sufficient clarification that the alarm type provided an adequate level of cover for the premises as per national guidance. It was also confirmed that there was no detection in the attic space. Detection in the attic space is required to ensure that if a fire was to occur in the attic, that the centre would be alerted to it in a timely manner to facilitate with a prompt evacuation. The person participating in management for the centre confirmed after the inspection that attic detection would be fitted; however, at the time of this report no date was provided.

The inspector reviewed three of the residents' PEEPs. While some of the information provided was clear two were observed to have potentially misleading information in them as they implied that the residents may refuse to evacuate. While this had occurred once for one resident, the PEEP did not provide learning from that refusal and did not adequately guide staff as to how to evacuate the resident to safety, if required. In the case of the other resident's PEEP, they had never refused to evacuate and therefore this information was misleading to staff. Quarterly fire evacuation drills were taking place and the inspector reviewed the documentation of the last two drills as other documentation had been archived. They contained details of scenarios used that recorded the possible source of the fire. An hours of darkness drill was observed to be completed. However, there was no evidence that a drill was completed with maximum resident numbers and minimum staffing levels to ensure that staff at night time could safely evacuate the residents.

In addition, the inspector observed a bed in the storage room which was an inner room within the staff bedroom of house one. A staff member also confirmed it was being used on occasion as a bedroom for staff on sleepover duty. That meant that staff would have to exit into another room before being able to exit onto a protected hallway in the event of an emergency evacuation. The person in charge confirmed

verbally to the inspector that the bed would be removed and the room no longer used as a bedroom.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

For the most part the person in charge had ensured that there were appropriate and suitable practices relating to the ordering, receipt, prescribing, storage, and administration of medicines. For example, from a review of medicines in one house that made up this centre, medicines were stored in a locked cabinet. There were periodic medication audits completed with the last one completed in January 2024. The inspector reviewed one resident's medication stock count for a controlled medicine and the stock was observed to be correct. This demonstrated that the medicine was being administered as prescribed.

A recent medicines error had taken place and had occurred due to a number of reasons. One of which, was due to the stock count of medicines received into the centre was not thoroughly checked.

In addition, the inspector observed that the time for administration recorded on the pharmacy label of another resident's medication did not match the prescription record. This was required to ensure medication was taken as prescribed. Therefore, based on the medication error and additionally the pharmacy label not matching the prescription, the inspector was not assured as to the quality of the systems for oversight of medicines received into the centre.

Judgment: Substantially compliant

Regulation 6: Health care

A sample of two residents' files demonstrated that residents had health and well being assessments completed which suitably identified their healthcare needs.

Once their healthcare needs were known, there were healthcare plans in place for identified supports required. Healthcare plans outlined supports provided to residents to experience the best possible health, for example an eating, drinking and swallowing plan was in place were required. From a sample of two residents' files, it was evident that residents were facilitated to attend appointments with health and social care professionals as required, for example an occupational therapist, an audiologist, GP and a dentist.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where residents presented with behaviour that may cause distress to themselves or others, the provider had arrangements in place to ensure those residents were supported. For example, residents had access to a behaviour therapist. While there were positive behaviour support plans in place to guide staff as to how to support the residents, from a review of two plans the inspector observed some out-of-date information. For example, with regard to arm splints which were no longer in use. This had the potential to mislead staff as to what supports residents may require. That could result in residents not always receiving care in line with their assessed needs.

Restrictive practices were logged and reviewed quarterly. For example, restrictions in place included a travel safety harness to support a resident to keep their seat belt on. It was evident that efforts were being made to reduce some restrictions to ensure the least restrictive were used for the shortest duration. For example, as mentioned above, one resident used to wear arm splints in an effort to reduce the levels of self-injurious behaviour they displayed. This practice was reviewed and deemed no longer required.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to safeguard residents. For example, there was an organisational child safeguarding policy in place and it was last reviewed in May 2023. Staff were trained in children first safeguarding training. One staff spoken with was clear on what to do in the event of a safeguarding concern. There were no safeguarding risks at the centre for the year preceding this inspection.

From a sample of one resident's intimate care plan, the inspector observed that there was clear guidance provided to staff as to how best to support them with regard to the provision of intimate care.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Cliff House OSV-0003257

Inspection ID: MON-0035150

Date of inspection: 11/06/2024

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 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The person in charge shall ensure staff have access to appropriate training, including refresher training as part of a continuous professional development program with suite of mandatory training modules in place for the staff team which are required for regular review and renewal.

To further enhance the skillset of the staff team the following additional mandatory training is being included in mandatory training requirements:

-Autism specific training from a recognised body to start in July 2024 with all staff to have completed by 30.09.23
-Training in resident sign language used: LAMH to be completed by all staff in September 2024
-Training in Total Communication System to be completed in September 2024
-Additional modules in Infection Control Training to be included in the current mandatory infection control training: Respiratory Hygiene and cough etiquette, Transmission based precautions and appropriate use of PPE. These additional modules are to be completed by all staff by the 30.08.24.

The Registered Provider is currently reviewing the system of completion of competency assessments for the staff team in areas of medication management training and infection control training to have a qualified and competent person with knowledge and expertise in place to complete these assessments. Planning in place to have a suitably qualified person complete these assessments which will commence in quarter four of 2024.

The Staff Training and Development Policy is under active review and will be finalised by 30.09.24 reflective of enhanced training requirements for the staff team and completion of staff assessments (frequency and who will complete) post mandatory training in

specified areas as discussed.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication: The registered provider shall ensure each resident is assisted and supported at all times to communicate with the residents' needs and wishes. Each resident has an individualised personal plan inclusive of a communication passport which will be enhanced to clearly outline the preferred and frequently used LAMH signs as part of their communication using sign language. The person in charge will ensure accessibility of sign language used by residents with pictures to be placed on resident notice boards.

The senior manager has scheduled training for the staff team with the LAMH communication office in sign language for completion in September 2024.

The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in individualised personal planning information. The person in charge has organised for the completion of a Speech and Language assessment in June 2024 with follow on written guidance to support a resident with potential for enhancement of communication skill set.

The senior manager is scheduling training for the staff team in September 2024 with a Speech and Language Therapist on the Total Communication System, an approach based on valuing all means of communication equally. No single form of communication is valued above others and the aim is for individuals with communication difficulties to communicate in whichever way, or combination of ways, works for each person. The designated centre will be moving away from a focus on the use of the picture exchange system to encompass all aspects of potential for communication with each resident. Resident communication passports will be reviewed and updated to be reflective of detailed guidance focusing on the total communication system and individualised for each resident's identified support needs.

PIC has sourced additional visuals for food items which are used in supporting the involvement of residents in menu planning, making changes to menus and expressing individualised choices and preferences for mealtimes.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

The registered provider ensures that effective fire management systems are in place including adequate precautions against the risk of fire, suitable firefighting equipment, building services, bedding and furnishings. Arrangements are in place to ensure maintenance of all fire equipment, means of escape
including emergency lighting.

Registered Provider has verified with external professional that the fire alarm detection system is fully compliant with current National Guidance and Code of Practice for Fire Safety in New and Existing Community Dwelling Houses with assurances of:
The fire alarm system is a Grade A system; LD1 systems are Grades B, C or D. Irish Standard 3218:2013+A1:2019 states that 'the highest level of protection would be a Grade A installation……' (Clause 10.2.1.3 Maximum and minimum levels of cover). Grade A systems would be the type of fire alarm system that is installed in hospitals, nursing homes, hotels, and most commercial buildings. Where the other grades of system are for lower risk premises.

While the code of practice for community dwelling houses (Clause: 3.3.14) refers to a LD1 system, a Grade A system affords a higher level of protection. It also provides a control panel (CIE) that gives the user more control over the system and also identifies the zone in which an activation occurs.

Registered provided has commissioned the installation of fire detectors in attic space and this was completed by qualified fore engineer in July 2024.

The fire alarm system has a separate test switch with no areas of the designated centre not covered by the fire alarm system.

The use of the inner rom as an additional sleepover room for staff members was ceased on 12th of June 2024 with removal of the bed completed.

PIC has reviewed and updated all resident (Personal Emergency Evacuation Plans) PEEPs to ensure inclusion of emergency plan guidance for evacuation with detailed step by step supports included for staff information. A copy of the emergency response plan is now filed with the PEEPs for ease of access. PIC has further enhanced the quality and information included in the PEEP ensuring individualised, person centred information detailing exact description of the specific supports required by each resident for the safe evacuation in case of emergency. All resident PEEPs were updated by 10th of July 2024.

PIC scheduled a fire drill with maximum number of residents and minimum number of staff completed by 8th July 2024.

PIC arranged for a review of all fire doors to have seals replaced as required ensuring no gaps in the seal of the fire doors as completed by July 10th 2024.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
The Person in charge shall ensure the centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines in line with the center's Medication Policy and Procedure.

Senior manager and person in charge issued two shared learnings on 12.06.24 for the staff team on:
1: Medication Stock Check, Ordering and Collection
2: Medication Administration
Significant detailed step by step guidance included required protocols to be followed and reflective of the Centre's Medication Management Policy. A follow-on staff meeting to discuss the medication management shared learning and protocols to be followed was completed on the 26th of June 2024. The person in charge has included the topic of medication management on the agenda of all planned supervision meetings with staff in July and August 2024.

Regular medication management audits are scheduled with an audit scheduled in August 2024. The medication management risk assessment assessing the level of compliance in place regarding best practice medication management and compliance with regulation 29 was reviewed on the 2nd of July 2024 by the senior manager and person in charge with additional control measures identified and implemented.

The person in charge shall ensure that where a pharmacist provides a record of medication related intervention in respect of a resident, such a record is kept in a safe and accessible place in the designated centre. The person in charge is currently planning for the change over to a new pharmacist in August 2024 and in the intervening period additional checks are in place to ensure accuracy of documentation received from the pharmacist is matching the prescription of the resident as received from the residents prescribing doctor. The medication stock checks are completed on arrival of all medication from the pharmacy with follow on weekly medication stock checks recorded and overseen by the person in charge.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The person in charge shall ensure that staff have up to date knowledge and skills appropriate to their role in responding to behaviour that is challenging and to support residents to manage their behaviour.

Each resident has an individualised behaviour support plan including proactive and reactive strategies individualised to each residents identified support needs. Regular visits by the behavioural specialist are scheduled with the person in charge and in June 2024 a review of documentation in the behaviour support plans was updated reflective of the most recent and updated individualised care planning recommended for each resident.

Regular onsite visits in place by the behaviour specialist and post review and updating of residents behaviour support planning information in June 2024 the behaviour specialist provided the person in charge and staff ream with written guidance and protocols for the implementation of the revised individualised behaviour support as completed on 11.07.24.
The person in charge will ensure all staff are familiar with updated behaviour support guidance and a staff sign off sheet is attached to the written guidance and the person in charge has the topic of behaviour support scheduled for the next staff meeting in August and in supervision meetings scheduled in July and August 2024. Incident data review meeting completed on the 11th of July and signed off by the person in charge and senior manager. The minutes will be circulated for staff attention and review with additional sign off sheet attached for staff attention.

The registered provider ensures that where restrictive procedures including physical, chemical or environmental restraint are used such are applied in accordance with national policy and evidence-based practice. Quarterly restrictive practice committee meetings are scheduled with a meeting planned for July 2024 to discuss all current restrictions used in the centre as a last resort when all other measures are deemed insufficient. Restrictions are required to be used for the least possible time with the least possible restraint for each resident and a restoration plan is in place for each resident. On a quarterly basis restrictive practice data collection is completed and discussed at the restrictive practice committee meeting attended by the senior manager, person in charge and behaviour specialist. Quarterly data is submitted to HIQA as per required quarterly notifications.

All residents as part of their care planning information have the following documentation in place for restrictive practices:
Restrictive practice assessment
Restrictive practice restoration plan
Restrictive practice consent
Restrictive practice register
Restrictive practice risk assessment

Each resident's individualised documentation regarding restrictive practice is scheduled for review in July 2024 ensuring the minimum restrictions deemed necessary for the safety of residents are accurately recorded and documented any time the restriction is activated.

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	30/09/2024
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	30/09/2024
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	Substantially Compliant	Yellow	30/12/2024

	development programme.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	10/07/2024
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.	Substantially Compliant	Yellow	10/07/2024
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 to no other resident.	Substantially Compliant	Yellow	26/06/2024
Regulation 07(3)	The registered provider shall ensure that where	Substantially Compliant	Yellow	11/07/2024

	required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.			