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:	DC8
Name of provider:	St John of God Community Services CLG
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	02 May 2024
Centre ID:	OSV-0003788
Fieldwork ID:	MON-0034768

About the designated centre

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

St John of God Kildare Services DC 8 is a large single story building that has been renovated to provide care for up to 14 residents, on its' own site on the outskirts of a large town in Co. Kildare. The centre is divided into two sections supporting both males and females who present with physical and intellectual disabilities. In addition, seven placements are dedicated to residents with a diagnosis of dementia. These residents have identified clinical and medical needs, for example, psychiatry and psychology input available to them through the clinical team. Residents are supported by nursing staff, health care assistants and social care workers. Residents have access to a large sensory garden on its grounds. The centre is accessible to local towns, shopping, public transport and community facilities. The centre also has replicated recreation spaces for residents to enjoy, including a salon, a cinema room, and a cafe. The person in charge is supported by two clinical nurse managers and a social care leader.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	13

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 2 May 2024	09:35hrs to 17:20hrs	Erin Clarke	Lead
Thursday 2 May 2024	09:35hrs to 17:20hrs	Marie Byrne	Support
Thursday 2 May 2024	14:40hrs to 17:20hrs	Michael Keating	Support

What residents told us and what inspectors observed

This announced inspection was carried out as part of the regulatory monitoring of the centre and to help inform a decision on the provider's application to renew the registration of the centre. Three inspectors of social services spent time in the centre with residents and staff, observing interactions, meeting with management, and reviewing documentation to form judgments on the quality and safety of the care and support provided to residents in the centre. The person in charge facilitated the inspection process and showed a good understanding of the aspects of service provision being assessed and how to implement positive changes within the service. The inspectors also met with a clinical nurse manager, the social care team leader, nursing staff, healthcare assistants, and household staff. All staff demonstrated a good understanding of the resident's specific needs and how to respond to these needs in line with their roles and responsibilities.

The centre is situated on the outskirts of a large town in Co. Kildare. It consists of a spacious single-story building that has undergone significant renovations following the transition of several residents into the community in 2017 as part of the provider's broader decongregation plan. The newer section of the centre is dedicated to providing tailored residential support to individuals with both an intellectual disability and a diagnosis of dementia. This section features a total of seven specifically designed rooms for residents with dementia. In the older part of the building, seven residents with varying physical and intellectual disabilities are accommodated. Although this section has not undergone the same level of renovation as the dementia-specific area, essential upgrades such as fire safety measures, flooring improvements, and kitchen enhancements have been implemented.

In the process of renewing the centre's registration for an additional three years, the provider submitted an application to include additional rooms in the floor plans of the designated centre. Some parts of the building did not fall within the floor plans of the designated centre and, as such, were unused or were only used as administration and office space. The inspectors were satisfied with the additional floor plans added to the centre's layout, as it aligned with the residents' needs and provided new recreational opportunities.

The three additional rooms were located alongside each other had recently been converted into activity areas of a high standard for all residents to enjoy. One room was a beauty salon where residents could have hair, hands, feet and aromatherapy treatments in a calm environment. During the inspection, the inspectors observed some residents enjoying this area on a one-to-one basis. The next room replicated a cinema room with red velvet curtains and popcorn-making facilities and had a large projector to show films. The walls were adorned with vinyl wraps featuring classic movie posters, creating an immersive and authentic cinematic atmosphere. One resident was supported in watching a film with their support staff, and the inspectors were informed that residents really enjoyed having this new addition to

the centre. The third room was designed as a café, complete with tea and coffee-making facilities for residents to enjoy meetings with visitors. The café also had a functioning kitchen that allowed residents to take part in cooking and baking.

All residents appeared very content in their home and while residents could not verbally communicate their views with inspectors, their expressions indicated that they were happy and well looked after while in the company of staff. Communal areas had arts and crafts facilities, assistive technology, sensory items, musical equipment and memory aids that were seen being used by residents as they were relaxing.

The residents observed staff supporting residents during mealtimes and providing drinks. These were relaxed occasions, and staff were seen assisting residents at their own pace and taking breaks to ensure that residents were supported according to their feeding and dietary needs. It was noted that freshly home-cooked meals were being prepared at the centre, with a slow cooker making chicken curry for dinner and vegetable soup being prepared for lunch.

The inspectors heard one resident express vocalisations that indicated that they were not happy in their environment. They were sat in a living room with another resident in the presence of two staff members. The inspectors observed staff respond promptly to the resident to address their needs and minimise any negative impact on the other resident. When the resident was being taken to their bedroom, they were seen smiling at the staff and had become calm and content again.

As this inspection was announced, feedback questionnaires for residents and their representatives had been sent in advance of the inspection. Residents, with the support of the staff team, filled out questionnaires in relation to the care and support they received prior to the inspection. In total the inspectors received 13 questionnaires. In the questionnaire, residents and family members rated areas of care and support related to the home, food, choices and decisions, staff and people they live with. All answers in the questionnaire indicated that the residents were happy with the majority of aspects of care and support. One resident said that they liked having regular staff who knew them well working with them. Another resident said they were very happy with their home and they loved the staff and the friends they lived with but mentioned a draft issue in one part of the centre due to old windows. Another resident was pleased with the recent makeover of their bedroom, which included new furniture and soft furnishings. A family member wrote on their questionnaire that their sibling was very happy living in the centre and found that the staff always informed the resident about what was happening in the centre and the support given. Another family member complimented the new café in the centre and said the staff were so "friendly, caring and gave wonderful care".

Overall, the inspectors found that residents were well supported in line with their assessed needs to lead comfortable and meaningful lives. The staff team and person in charge were observed to be committed to the delivery of a good-quality service. The staff team that met with the inspectors were caring in their interactions with residents. They spoke about their needs in a respectful manner and were knowledgeable about the residents' likes and dislikes. However, some resources

within the centre required improvement to ensure residents were afforded opportunities to access the community in line with their preferences. Due to the limited accessible vehicles in the centre compared to the requirements of most residents, unplanned community access for residents was not always possible.

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

This inspection identified that the management team centre was responsive to addressing previously identified issues and continually improving the service and living environment to meet the needs of residents. The inspectors identified that further improvement was needed in relation to some provider strategies for policy renewals, provision of administration support in the centre, and access to accessible vehicles.

The centre was last inspected in December 2023. This unannounced thematic inspection assessed the provider's implementation of the 2013 National Standards for Residential Services for Children and Adults with Disabilities regarding physical, environmental, and rights restrictions. The thematic inspection did not require a submitted compliance plan to address any identified areas of improvement. However, the person in charge used these areas as part of the quality improvement plan for the centre, which will be discussed later in the report.

The management structure in the centre was clearly defined, with associated responsibilities and lines of authority. The governance structure had recently been strengthened with the appointment of a new programme manager within the week of the inspection. The position had been unfilled for long periods in 2023 and 2022, leading to a provider-owned high-risk assessment of the potential for poor service provision within the region due to the role being unfilled.

The person in charge was full-time and found to be suitably skilled, experienced, and qualified for their role. The person in charge reported to the regional director in the absence of the programme manager, and there were systems for them to communicate. The regional director reported to the Chief Executive Officer (CEO). The person in charge held a larger role in the organisation as a residential co-ordinator with additional responsibilities and was supported in their role by two clinical nurse managers and a social care leader. As the person in charge was not based in the centre on a daily basis and the other members of the management team had no supernumerary hours, the inspectors found that this had affected certain aspects of the centre's operations. In particular, the scheduling of team meetings, notification of incidents, and updating personal plans.

The provider and local management team had implemented management systems

to ensure that the centre was effectively monitored. Annual reviews, six-monthly reports, and a suite of audits had been carried out, with actions identified to drive quality improvement. The local management team monitored quality improvement actions and addressed those within their control. Some actions highlighted by the person in charge and those in audits, such as the requirement for further premises work, in particular, the internal courtyard to improve accessibility and to make it more inviting, were funding dependent.

The provider had arrangements in place to review and monitor the care and support provided to residents, which included a number of audits, regular meetings and six monthly unannounced quality and safety reviews. Unannounced visits had taken place in June and December 2023 by the provider as legally mandated. The purpose of these visits is to review the quality and safety of care provided in the centre. The inspectors read the reports written regarding these visits. There was evidence that actions to address areas requiring improvement were being progressed or had been completed. It was noted that overall actions were also consistent with the findings of this report, for example, the scheduling of staff meetings and training and the need to address premises issues in the centre.

The staff skill mix and complement were appropriate to the number and assessed needs of residents. On the last inspection in January 2024, there were some vacancies in the centre across all grades, and job offers were on hold due to a recruitment freeze implemented within the sector. These positions had since been filled, and as a result, there was a lesser reliance on agency staff. The social care leader post was a new position in the centre and aimed to promote and further develop social engagement within the centre and the wider community for residents.

The provider had identified that there was a requirement for non-nursing staff to receive rescue medicine training in epilepsy and also the safe administration of routine medicines. This would allow non-nursing staff to accompany residents outside of the centre without a nurse present. Seven staff had received this training, and this training was ongoing. While this training was not fully implemented, the inspectors could not identify any adverse impact on residents. Inspectors were informed that due to the availability of nursing staff, this did not create a barrier for residents to access the community and residents did not have to return to the centre to have medicines administered. The person in charge told the inspectors it was a priority for the service to have all training completed in order to facilitate holidays for residents in the summertime and that they were on track for doing so.

There were arrangements for the support and supervision of staff working in the centre, such as management presence and formal performance and supervision meetings. Staff could also contact an on-call service for support outside of normal working hours. Staff were required to attend staff meetings at regular intervals, which provided an opportunity for them to raise any concerns regarding the quality and safety of care provided to residents and be kept informed of service developments.Such arrangements are a requirement of the regulations. The inspectors requested to view staff meetings from the previous 12 months. The provider's six-month unannounced audit self-identified that the frequency of staff meetings required improvement, as only two such meetings had occurred in 2023.

This improvement is captured under Regulation 23: Governance and management.

The provider had submitted an application to renew the centre's registration. The application contained the required information set out under this regulation and the related schedules, such as floor plans, a statement of purpose, and the residents' guide. After reviewing this documentation, some amendments were needed, and these were made known to the centre's management team for submission post-inspection.

Registration Regulation 5: Application for registration or renewal of registration

This inspection was conducted to inform a registration renewal of this centre. Part of this decision is based on the information submitted by the provider's application to the Health Information and Quality Authority (HIQA). The provider had submitted all of the required information; however, the statement of purpose required review to reflect changes to the staffing and governance structure of the centre. The floorplans also required updating due to several discrepancies between the floorplan layout and a walkabout of the centre.

Judgment: Substantially compliant

Regulation 14: Persons in charge

The provider had appointed a full-time person in charge. The person was found to be suitably skilled and experienced for the role and possessed relevant qualifications in social care and management.

They demonstrated a very good knowledge of the residents' needs in the centre and provided good leadership to the staff team.

Judgment: Compliant

Regulation 15: Staffing

The statement of purpose for the centre states that the centre has a total complement of 28.88 whole-time equivalence (WTE) front-line staff that consists of nursing staff, social care staff and health care assistants. There were some gaps in staff cover due to statutory leave and one vacancy, but on review of the rosters, these were well managed through a small pool of regular relief and agency staff that were used to cover absences in the centre.

On the day of the inspection, the inspectors had the opportunity to speak with several staff members. Staff were knowledgeable about residents' specific needs, risks, likes, and dislikes, and all staff expressed that they enjoyed supporting the residents. All interactions observed were caring, supportive and reflective of residents' dignity and privacy.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were required to complete a suite of training as part of their professional development and to support them in the delivery of appropriate care and support to residents. The training included safeguarding residents, first aid, supporting residents with modified diets, fire safety, manual handling and epilepsy. The provider's annual review of the quality and safety of the centre for 2023 identified that some improvements were required in the provision of training due to identified gaps between refresher sessions. For example, on the day of the inspection, four staff members were required to have fire safety training, six were required to manage behaviours of concern, and five were required to have dysphagia training. Safe administered of medicines had been identified as a recent requirement but had not commenced at the time of the inspection.

Regular supervision conversations were held with staff, again, there was a clear system of recording of completion of these conversations and ensuring that the schedule of supervision was overseen.

The person in charge and supporting managers provided informal support and formal supervision to staff in line with the provider's supervision and probation policies. Records of formal supervision and probation reviews were well maintained. The inspectors reviewed a sample of 16 staff supervision sessions and found that they were comprehensive, and staff could raise concerns if required. A review of the records of these discussions showed that they were meaningful two-way conversations. Staff were facilitated to identify areas of self-development, and the person in charge identified any areas requiring improvement. Examples of these discussions included meaningful days for residents, resident goals, shift lead roles, roles and responsibilities, keyworker roles and residents' rights.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were management systems in place to support the delivery of a service that was safe, consistent and appropriate to residents' needs. Generally, the provider had

ensured that the centre was well-resourced to meet residents' assessed needs; for example, staffing arrangements were appropriate. The staff skill mix and complement were appropriate to the number and assessed needs of residents. Effective arrangements were also made to ensure continuity of care for residents. However, improvements were identified in the provision of accessible transport options for residents. The centre had two dedicated vehicles for residents' use. Both vehicles could only transport one wheelchair user at a time and with 12 wheelchair users in the centre this required careful and considerate planning by staff. The inspectors were not assured the provision of transport options fully met the assessed needs of residents.

The provider had completed an annual review and unannounced visits twice yearly to review the quality and safety of care provided in the centre, as required by the regulations. The six-month visit followed a standardised process, which was replicated throughout the wider organisation. The process involved a quality and safety team member visiting the centre unannounced and meeting with residents, staff, and management. A review of the systems and procedures also took place during this visit. A review of the reports of these visits indicated a detailed review and began with a review of the actions required from the previous visit. The views of residents and staff were elicited as part of the review, which examined various aspects of life in the designated centre.

This regulation also requires the provider to 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 are in accordance with standards. The review should also include consultation with residents and their representatives. The annual review for 2023 was submitted to the office of the Chief Inspector in advance of the announced inspection. The inspectors found that while the annual review overall captured its purpose, some further improvements were required. For example, it was not evident in the review that residents or residents' representatives were consulted to gather their views and opinions. In addition, there was no systemic process for completing the annual review compared to the six-month visits and it required further attention from the provider.

While there was evidence of good management oversight in many areas of the service provided, the need for improved governance processes in some specific areas was identified during the inspection. The inspectors found the allocated supernumerary hours in order to fulfil regulatory responsibilities in the centre were low compared to the size and service delivery of the centre and required review by the provider.

As detailed under Regulation 4: Written Policies and Procedures, the inspectors found considerable delays in implementing pertinent updated policies reflecting important legislative changes nationally. Such was the delay in updating policies that a following three-year review was nearly due by the time policies were updated. The system and process for reviewing policies required attention by the provider.

The provider was also requested to review the membership of the admissions committee to ensure the person in charge formed part of the admission decision

making process for the centre and records were maintained in the centre for review on inspection.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The inspectors found that admissions to the centre generally followed clear criteria. However, the provider's admission, discharge, and transition policy had not been updated and circulated within the service as required. Additionally, the person in charge was not part of the committee responsible for managing transitions into the centre, despite having regulatory responsibilities for ensuring that the centre met the needs of all potential residents and ensuring a comprehensive assessment of needs had taken place prior to admission.

Despite the improvements required at a provider level and actioned under regulation 23, the inspectors were satisfied that the person demonstrated management of admissions within their control and also between the two models of care being provided in the centre. For example, the person in charge identified that better accommodation options were available for one resident living in the centre, and they had transitioned to a centre where they could be more immersed in their local community. Also, improvements in one resident's medical condition after moving into the centre led the person in charge to advocate for additional overhead tracking hoists in the non-dementia-specific service area of the centre. These hoists would facilitate the internal transfer of the resident so that they could be with their peer group.

Judgment: Compliant

Regulation 31: Notification of incidents

Documentation related to notifications, which the provider must submit to the Chief Inspector under the regulations, was reviewed during this inspection. Such notifications are important in order to provide information around the running of a designated centre and matters that could negatively impact residents. Overall, there was a low level of adverse events occurring in the centre that required notification; however, improvement was required to ensure these types of notifications were submitted within the required time frame.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Under this regulation, the provider must have specific policies in place and ensure that such policies are reviewed at intervals that do not exceed three years. Despite this, the majority of policies provided during this inspection were noted as being overdue review since 2022. In light of this, the inspectors afforded an opportunity to confirm whether these policies had been reviewed since these dates. Following the inspection, it was confirmed that six of the 21 required policies required updating. It was clarified that the admissions policy outstanding since October 2022 had been updated in April 2024 and was due for circulation. The policy regarding communication with residents, due in September 2022, was near completion. The use of restrictive practices that was meant to be reviewed by March 2022 was with board members for approval. The policy for residents' personal possessions, which was due for an update in March 2022, was under committee review. However, no information regarding when this update would be made available was provided. Similarly, policies on staff training and development, recruitment, and Garda vetting were due for review between 2019 and 2023, and there was no further information regarding when the provider would address these policies. After reviewing the information and considering the time delays in reviewing policies, the inspectors were not assured that an effective system was in place to update policies in line with best practices.

Judgment: Not compliant

Quality and safety

The inspectors found that the quality and safety of care which residents received was held to a good standard. This centre focused on person-centred care, and it was clear that the service was continually evolving since being redesigned in 2018 to deliver dementia-specific services.

Inspectors on their walkabout of the centre noted that the residents' bedrooms were thoughtfully decorated to reflect their unique preferences and personalities. Additionally, memory boxes were placed outside some residents' bedrooms to provide insight into their individual likes, hobbies, and interests. These memory boxes also served as aids for residents with memory deficits, helping them to recognise and locate their own bedrooms.

In the dementia-specific area of the centre, it was found that best practices were being followed to provide physical access for residents and create a dementia-friendly environment. Many of the bedrooms and bathrooms were equipped with built-in tracking hoists, ensuring safe and efficient mobility for the residents. The lighting was bright, even, and natural, and automatic light sensors were in place where required to minimise confusion and the adapted use of patterns, contrast,

and colour made the environment easier to perceive and improved orientation and spatial perception. A prominent colour contrast was used to highlight important objects and add clarity to the environment, such as door frames, grab rails, toilet seats and signs.

The provider person in charge had implemented good fire safety systems in the centre. Fire evacuation plans and individual evacuation plans had been prepared to be followed in the event of a fire, and the effectiveness of the plans was tested as part of fire drills carried out in the centre. The inspectors tested the fire doors, including corridors and bedroom doors, by releasing them and observed that they closed properly. They viewed fire evacuation procedures in prominent areas of the building that identified five fire zones in line with the building's fire compartment sections through a colour-coded system. Notably, all the bedroom doors were sufficiently wide to facilitate bed evacuation in the event of a fire, prioritising the safety of the residents.

The inspectors also observed that residents were able to move around the facility without encountering unnecessary restrictions. For instance, the entrance doors to the centre were equipped with sensors, enabling them to open and close automatically, thereby promoting movement within the centre. Since the previous inspection in January, some internal doors operated via a swipe card system had been removed, further allowing residents access around the centre.

The centre was visibly very clean on the day of inspection. Support staff and dedicated household staff were observed to be engaging in cleaning duties, and guidance was in place to ensure the centre was cleaned effectively on a regular basis. The outdoor space included a large driveway and side and rear gardens. The gardens were pleasant and spacious and contained a sensory walkway. The person in charge had identified improvements needed to improve the accessibility of this area for all residents, and some work had commenced since the last inspection. A patio area was also provided for outdoor barbecues.

Appropriate arrangements were in place to safeguard residents from abuse. For example, staff had received relevant training to support them in the prevention and appropriate response to abuse. Safeguarding protocols were in place to address potential risks, but there were no active safeguarding concerns at the time of the inspection. While 14 residents lived in this centre, two distinct services were offered, and residents lived together with compatible peers who were reported to get along well.

A number of residents had specific dietary requirements and also required specific assistance with regards to mealtimes. Staff who were on duty clearly explained aspects of residents dietary needs and it was clear that they benefited from a planned approach in this area of care.

Regulation 11: Visits

It was clear that residents were being supported to visit and be visited by the important people in their lives.

Visiting arrangements were detailed in the provider's visiting policy, the statement of purpose and the residents' guide which were all available for review in the designated centre. These documents detailed how visits were facilitated unless it posed a risk or if a resident did not wish to receive visitors. The layout of this centre, provided residents with various rooms that they could meet with their visitors in private, if they so wished.

Judgment: Compliant

Regulation 18: Food and nutrition

The residents' nutritional needs were being well supported. The centre had three well-equipped kitchens where food could be stored and prepared in hygienic conditions.

The inspectors observed that a good range of fresh food items was in stock, and where there were specific dietary requirements and different food preferences, these were stored in separate presses. For example, gluten-free food was kept separate and had its own food preparation applications to avoid cross-contamination.

There was evidence that residents were supported with regular reviews by a speech and language therapist regarding their high medical needs in relation to safe swallowing. Guidance on particular modified consistency diets that residents required were outlined in their personal plans. Staff members were observed to follow these guidelines when preparing food and drink for residents as observed during the lunch time experience. Each resident had a personalised mealtime placemat that acted as a communication aid for staff supporting residents with their specific needs.

Judgment: Compliant

Regulation 27: Protection against infection

There were systems in place for the prevention and management of risks associated with infection. There was infection control guidance and there were protocols in place in the centre.

The centre was clean upon visual inspection, and various hand sanitising stations were available throughout the centre and hand washing facilities. Staff were completing scheduled cleaning, and suitable guidance was in place for the cleaning

and sanitisation of both communal and private areas of the centre.

Judgment: Compliant

Regulation 28: Fire precautions

The person in charge had identified areas for improvement within the fire safety plan for the centre and had prioritised fire safety awareness among all staff. This included providing on-site fire safety training to increase staff's knowledge of the fire evacuation process and routes, developing more easily identified fire zones and evacuation maps, and conducting more detailed fire drills.

The person in charge had prepared evacuation plans to be followed in the event of the fire alarm activating, and each resident had their own personal emergency evacuation plan (PEEP), which outlined the supports they required in evacuating. All residents were required to undergo either a bed evacuation or ski sheet evacuation. The fire evacuation plan also detailed how individual PEEPs worked together, and determined the order of evacuation based on the fire zones.

Fire drills, including drills reflective of night-time scenarios were carried out to test the effectiveness of the evacuation plans. These were conducted with the person in charge and the fire officer. The inspectors viewed four fire drills from 2023 and two completed in 2024. In 2024, there was evidence that the fire drills were more detailed. Efforts were made to improve the fire evacuation process, and actions were taken to address any issues encountered and improve the efficiency of the evacuation process. This included specifying the location of the intended fire, determining the number of staff supporting residents, outlining the direction the evacuation would take, and gathering insights from the drill.

On the walkabout, the inspectors noted a gap between one set of double fire doors and the absence of a thumb lock on one external exit. These were escalated by the person in charge and rectified post-inspection with confirmation of completion submitted to the Chief Inspector.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspectors noted improvement in the application of restrictive practices following the previous thematic inspection and also through learning within the organisation. The person in charge demonstrated a commitment to minimising the use of the restrictions in the centre and promoting a human-rights focus.

The person in charge maintained a restrictive practice register and had referred any

restrictions to the provider's human rights committee for oversight and updating. Overall, there was a low requirement for restrictions, and the centre presented as a restriction-free environment.

Upon reviewing the use of bedrails at the centre, including the rationale and associated risks, it was determined that less restrictive options would be more appropriate and had already been implemented. Internal locked doors had been removed, and a lock on a pedestal gate was addressed. The use of hourly nightly checks was also reviewed to ensure that there was a medical needs' assessment and rationale when in use.

The policy for managing restrictive practices, which the provider was required to review and update in accordance with legislative and best practices, was two years overdue. The inspectors were informed that a draft version was sent to board members for review and approval. While there had been considerable delay in implementing an updated policy outlining the procedures for managing restrictive practices in the centre, the inspectors were satisfied that the person in charge had aligned practices with available updated guidance.

Overall, there was a low requirement for positive behavioural support to help residents manage their behaviours of concern. However, there were formalised arrangements in place to support residents with behaviours of concern if and when required.

Judgment: Compliant

Regulation 8: Protection

Staff working in the centre completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns. Staff spoken with during the inspection were aware of the procedures for reporting safeguarding concerns.

Personal and intimate care plans had been developed to guide staff in supporting residents in a manner that respected their privacy and dignity.

Overall, safeguarding incidents rarely occurred in the centre in recent times. There were no current open safeguarding plans, and those that were closed had associated risk assessments and management plans that remained open.

Judgment: Compliant

Regulation 9: Residents' rights

The inspectors found that the provider had responded to their residents' ageing demographic within the wider organisation by establishing a specialised service that allowed residents to remain in their community and with their peers.

The centre's layout and additional communal space increased residents' comfort levels. These helped ensure residents had separate and quiet spaces to relax if they so wished.

The centre was operated in a way that respected and celebrated each resident's individuality and rights. Residents living in the centre were at different life stages and had varying support needs. These differences were respected and accommodated. Where one resident wished to move to closer to their local community, the person in charge and staff supported them with the transition.

Seventeen staff members had completed training in human rights, and there were various examples where the choices and preferences of residents were being respected. One staff member emphasized the importance of encouraging residents' communication and freedom of expression and finding alternative activities for residents who were unable to leave the centre due to illness. The staff member also said they had completed phlebotomy training, which allowed them to take residents' blood, which had a positive impact on residents as they were supported by a familiar healthcare professional.

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	
Registration Regulation 5: Application for registration or renewal of registration	Substantially compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for DC8 OSV-0003788

Inspection ID: MON-0034768

Date of inspection: 02/05/2024

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
Registration Regulation 5: Application for registration or renewal of registration	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: Person in charge shall ensure that all information on the SOP will be updated. This will include updates to reflect staffing and governance structure. 09.05.2024 Completed Person in charge shall ensure that all floor plans have are updated. 09.05.2024 Completed	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Person in charge shall ensure that all outstanding mandatory training will be completed. Due for completion: 12.09.2024	
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: Person in charge and program manager shall ensure a systematic review and the implementation of a process for the completion of the annual review residents or residents' representatives consultation is captured. Due for completion 31.10.2024 Person in charge shall complete roster review to maximize resource usage, to ensure governance and management role is carried out in line with regulation. Due for completion: 24.07.2024	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Person in charge shall ensure that all regulatory notification are reported in line with required time frame for submission. Completed: 07.05.2024	
Regulation 4: Written policies and procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: The provider shall ensure that all schedule 5 policies are reviewed and updated. 30.09.2024 Due for Completion.	

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
Registration Regulation 5(1)	A person seeking to register a designated centre, including a person carrying on the business of a designated centre in accordance with section 69 of the Act, shall make an application for its registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 1.	Substantially Compliant	Yellow	09/05/2024
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 development programme.	Substantially Compliant	Yellow	12/09/2024
Regulation	The registered	Substantially	Yellow	24/07/2024

23(1)(a)	provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Compliant		
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	31/10/2024
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	07/05/2024
Regulation 31(3)(e)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated	Not Compliant	Orange	07/05/2024

	centre: any deaths, including cause of death, not required to be notified under paragraph (1)(a).			
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	30/09/2024