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:	Liffey 6
Name of provider:	St John of God Community Services CLG
Address of centre:	Dublin 22
Type of inspection:	Announced
Date of inspection:	29 June 2023
Centre ID:	OSV-0003921
Fieldwork ID:	MON-0030979

About the designated centre

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

Liffey 6 is a designated centre operated by St. John of God Community Services. Liffey 6 provides residential services to male and female residents over the age of 18 in two separate houses in nearby separate housing estates in Co, Dublin. The maximum capacity of the combined service is eight residents. One house, a semi detached bungalow, has four bedrooms available to residents, a sitting room, a kitchen dining area, accessible showering and bathing areas and an utility area. The other house is a two storey detached house with four bedrooms available to residents. One bedroom on the ground floor is accessible with an ensuite. There are separate showering areas off the kitchen and upstairs. All residents have access to multi-disciplinary team including social workers, physiotherapists, occupational therapists, speech and language therapy and psychology. There are service vehicles available for the transport of residents and the location is also serviced well by public transport to shops, restaurants and social activities. Residents are supported by a team of social care workers and a social care leader.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

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 29 June 2023	09:50hrs to 18:10hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

This inspection was completed to monitor adherence to the compliance plan response submitted by the provider following an inspection by an inspector of social services in February 2023. It was evidenced on the day of inspection that improvements had occurred since that inspection in areas such as premises and fire safety measures. Residents living in the designated centre enjoyed a good quality of life where they were encouraged to lead active lifestyles to the best of their capacity while at the same time being protected. As discussed in the report improvements were identified in fire safety measures, residents finances, healthcare planning and review of restrictive practices.

This designated centre provides residential services to eight residents in two houses in nearby separate housing estates in Co, Dublin. On arrival to the first house, the inspector was welcomed by the person participating in management and the person in charge. The inspector did not get to meet with the four residents living in this house as they were away on an organised day trip with their day service.

This house consists of three upstairs bedrooms for residents and one sleepover room for staff. Two bathrooms upstairs were remodelled during the summer of 2022 to better suit the needs of residents following concerns raised during inspections of the centre. An unused bedroom had been changed into a snug for residents' use. Since the last inspection, this room had been cleared of storage items that had impacted the room's function. The inspector observed this space being used as an area of reflection to support one resident who recently experienced a bereavement. The house also could support one resident with mobility requirements with a bedroom and an ensuite bathroom on the ground floor. The residents were also provided with a combined sitting and dining room that was homely and welcoming, with an array of photographs and pictures of residents.

As this inspection was announced, feedback questionnaires for residents and their representatives were sent in advance of the inspection. Eight were returned to the inspector. Residents had been supported by staff to answer the questions. One resident said their home was "nice and quiet". Another mentioned they liked going to an art class and a community social group. One section of the questionnaire asks residents if there is anything they would like to change about their home or surroundings and the majority of residents responded that they were happy with all aspects of their home. One resident's questionnaire did state that they would like to have an accessible back garden with furniture as they were not using it currently. This action was already listed as an action on the provider's improvement plan for the centre.

The person in charge outlined works that still had to be completed to the back garden but pointed out new furniture that had been purchased and outdoor storage for mops and mop buckets. The garden also had raised flower beds in which

strawberries were growing planted by residents with the support of staff.

The inspector noticed during a walk around of the house that residents' ability to self-immobilise in the centre had increased since the previous inspection. During the prior inspection, it was discovered that a fire door was wedged open. It has been explained that this was done to make it easier for a resident who needed to use a rollator to get around their home. The door's weight was difficult for the resident to navigate independently. In order to maintain the effectiveness of the fire containment measures within the house and also promote accessibility within the centre, the provider installed a new fire door closure.

In the second house, the inspector met with two of the four residents that lived in this house. Residents engaged in non-verbal means of communication, and the inspector observed that staff were well-known to residents could understand their needs. The inspector spent some time with residents in the living room as they arrived back from day services. They were provided with hot drinks as they rested. Residents chose not to engage with the inspector directly but appeared comfortable with staff. Staff spoken with informed the inspector that residents could make their needs known through expression and body language.

On speaking with staff throughout the day, the inspector found that they were knowledgeable of residents' needs and the supports in place to meet those needs. Staff were aware of each resident's likes and preferences. The inspector observed that residents appeared relaxed and happy in the company of staff and that staff were respectful towards residents through positive, jovial and caring interactions.

A visual roster was in place to show residents which staff were on duty that day. Residents were seen to be familiar with staff members and knew them well. Some residents had communication support needs and used other forms modes of communication, including non-verbal means. Staff members were seen to be knowledgeable and familiar with residents' expressed needs and responded to these needs in a timely manner.

There was evidence that residents and their representatives were consulted and communicated with about decisions regarding their care and the running of their home. Each of the residents had regular one-to-one meetings with their assigned key workers, and there were weekly resident meetings. Residents were enabled and assisted in communicating their needs, preferences and choices at these meetings concerning activities, daily routines, money and meal choices. While there were many examples found of where residents were found to be consulted with purchases made on their behalf, in one case, the inspector found limited evidence that a resident had been consulted with regarding a purchase of a living room chair. This is discussed further under Regulation 12: residents' finances.

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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

The inspector found that the provider had good arrangements in place to assure itself that, overall, a safe and good quality service was being provided to the residents who availed of the residential service in the designated centre. The service was led by a capable person in charge, supported by a staff team and provider, who were knowledgeable about the support needs of the residents. Further improvement was needed with training requirements however, these were known to the provider and were currently being progressed.

Following the inspection in February 2023, the provider submitted to the Chief Inspector a compliance plan outlining how they will comply with the regulations. The completion deadlines ranged from one to seven months post-inspection. As a result, certain tasks were still in progress when the follow-up inspection took place. However, the inspector noticed changes that had been made to the physical environment that were beneficial to the residents. One of these changes was the installation of automatic fire door hold-open systems, which made it easier for residents to move freely around their home.

The centre was managed by a suitably qualified and experienced person. They had taken up the position in November 2022 and were appointed as the person in charge in January 2023. This allowed them time to become acquainted with the residents, staff and organisation The person in charge said they felt supported by their managers and also through peer support from other persons in charge within the organisation. The person in charge attended monthly management meetings with evidence of communication of shared learning at these meetings. In addition, the provider ensured that support was given to the person in charge in completing audits of the centre, with managers from other areas in the organisation attending the centre to complete these audits while the person in charge was still getting to know the role.

Staffing arrangements included enough staff to meet the needs of residents and were in line with the statement of purpose. Both houses had their full complement of staff, and there were no staff vacancies in the centre. To support continuity of care, when staff were on leave, staff working in the centre would cover their shift where possible. If relief staff were required, the person in charge endeavoured to employ staff who were familiar to residents. At night, the provider had increased resources in one house so that the healthcare needs of one resident could be supported at all times.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application to register this centre in line with the requirements outlined in this regulation.

Judgment: Compliant

Regulation 14: Persons in charge

The social care leader who is also the person in charge is employed in a full-time capacity with an oversight over the two houses that make up the designated centre. The position is supernumerary to the roster to allow for sufficient management time to ensure compliance with regulatory responsibilities.

The inspector found that the the person in charge had the appropriate qualifications and skills and sufficient practice and management experience to oversee the residential service to meet its stated purpose, aims and objectives.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient staff employed in the centre, with the right skills and experience to meet the needs of the residents. Where additional staffing resources were required from time to time, the provider had relief staff available to this centre, who were familiar with its operations and with the needs of the residents.

The person in charge maintained planned and actual staff rosters. The inspector viewed a sample of the recent rosters and found that they showed the names of staff working in the centre during the day and night, along with other relevant information.

Throughout the day, staff who spoke with the inspector demonstrated a good understanding of the residents' needs and were knowledgeable of policies and procedures relating to the general welfare and protection of residents living in this centre.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the training and development initiatives for staff. There was a staff training and development policy. A training programme was in place and coordinated by the provider's training department. Overall, training had been provided to staff to support them in their role and to improve outcomes for the residents. Examples of training completed included safeguarding, the safe administration of medicines, manual handling, first aid, diabetes, infection prevention and control and fire safety. Staff had attended all mandatory training. As highlighted in the provider's six-month unannounced audit, there were gaps in a number of training schedules, partly due to new staff commencing in the centre. However, the inspector found there was good oversight of these requirements and action taken to address these gaps. For example, dates had been set for the coming weeks for training in positive behaviour support. The person in charge also identified that human rights training online would be beneficial for all and spoke about it with staff in a recent staff meeting.

Team meetings were occurring regularly, and agenda items included areas such as incidents, accidents, health and safety, audits, policies and procedures, management support, risk management, fire safety, residents' goals, and residents' plans.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were management systems in place to ensure that the supports provided were safe and appropriate to residents' needs, and the management structure ensured clear lines of authority and accountability. Management presence in the centre provided all staff with opportunities for management supervision and support. Staff meetings were regularly taking place, which provided staff with opportunities to raise any concerns they may have or improvements that could be made to the quality of the delivery of service to residents.

The provider had sufficiently resourced the centre to ensure the effective delivery of care and support. An annual review and unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed, as required by the regulations. There was evidence that where issues had been identified, actions were completed to address these matters.

The provider had enhanced its monitoring systems at an organisational level following an inspection in another designated centre. These changes occurred so that the CEO and board members would be better informed of the operations of the multiple designated centres within the region. These included increased reporting mechanisms from local to senior management. Also, the status of actions and

recommendations arising from the comprehensive six-month unannounced audits completed by the quality and safety team were closely tracked for completion or escalation.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider submitted an up-to-date statement of purpose along with the application for the renewal of registration for the centre. The statement of purpose contained all required information, as per Schedule 1. It accurately described the service provided in the designated centre and was reviewed at regular intervals.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had a complaints policy, which outlined how complaints would be dealt with. The complaints procedure included an appeals process. A complaints officer had been appointed to deal with complaints, as outlined in the organisation's complaints policy.

Residents were aware of their right to make a complaint and had been supported by staff to make complaints regarding issues affecting them. For example, a complaint had been made on behalf of the residents against the housing authority regarding delays in the maintenance of the properties and upkeep.

There was access and information available to residents in relation to advocacy services. One resident had accessed the services of an independent advocate in 2022. This informed an amicable resolution for all parties involved.

Judgment: Compliant

Quality and safety

The inspector found that the provider and person in charge were endeavouring to ensure that residents' wellbeing and welfare was maintained to a good standard. The person in charge and staff were striving to ensure that residents lived in a supportive environment where they were encouraged to live as independently as they were capable of. Since the last inspection, there had been a number of

improvements in the centre which had resulted in positive outcomes for residents. However, improvements were needed to ensure that outstanding actions relating to restrictive practices and fire safety were completed and in a timely manner. Also, on this inspection, it was found that improvement was needed with some procedures related to resident expenditure.

A review of the fees outlined in residents' contracts of care found they were generally correct and up-to-date with the costs payable to residents. A review of the receipts maintained of purchases made with residents' monies indicated a good level of oversight and auditing to ensure processes followed the provider's policy and residents' monies were safeguarded. Where residents did not have access to their bank accounts due to being managed by external third parties, there was evidence that the residents were supported in gaining access. It was unclear from reading the contracts of care of the requirements of residents to purchase communal area furniture and therefore required clarity.

Residents had access to multidisciplinary services as appropriate to their needs, including psychiatry, physiotherapy, psychology, social work, and positive behaviour support. Residents were provided with a personal plan. The plan detailed their needs and outlined the supports they required to maximise their personal development. The plans included residents' positive behavioural support plans, safety plans, mental health and wellbeing support plans, safeguarding plans and support plans.

Personal plans in place had been reviewed with the involvement of the individual resident's multidisciplinary team, the resident and their representatives. The effectiveness of the plans were assessed as part of a review as required by the regulations. Health action plans were in place for residents identified to require the same. Specific goals were identified for residents. Records were maintained of session planning to achieve goals and one-to-one meetings to record progress in achieving identified goals.

The inspector found that the house was suitably equipped with fire detection systems, fire fighting equipment and emergency lighting. There was evidence these were regularly checked and maintained; however, improvements were required in the record-keeping of service certificates in line with the requirements of the regulations. Also, the provider's improvement plan identified further works were required to fire doors within the centre.

Regulation 12: Personal possessions

The inspector read documentation relating to the purchase of a dining room chair for one resident for a sizeable amount of money. Due to a safety incident four months later, the resident could no longer use this chair when assessed by an occupational therapist, and a prescribed chair was in place at the time of the incident. The provider was required to ensure that all purchases made with residents' monies were in line with residents' preferences and contracts of care. It

was unclear from reviewing records relating to the purchase of the chair that the resident was involved in the decision-making process. For example, it was not linked to any personal goal of the resident and had not been discussed in any recorded meeting with the resident. The contracts of care also did not state that residents would be financially responsible for purchasing communal area furniture. At the time of the inspection, the chair was no longer being used by the resident, and it remained in the dining room.

Judgment: Not compliant

Regulation 13: General welfare and development

Resident's personal development was promoted through the actions of the staff team and management of the centre. The registered provider ensured that each resident had appropriate care and support to access activities of choice and recreation. This included retirement plans and attending day services on a reduced scheduled as per individual wishes. Staff planned activities with residents on a weekly basis. The activities reflected residents' known interests.

Judgment: Compliant

Regulation 17: Premises

Overall the provider addressed the findings from the previous inspection. Improvements had been made to the design and layout of the premises to ensure that residents had an accessible, safe and comfortable environment to live in. This enabled the promotion of independence, recreation and leisure for the residents throughout their time in the centre. Some actions were not due for completion until September 2023 and therefore were still in progress at the time of the inspection, including garden works and floor damage repair.

Judgment: Compliant

Regulation 28: Fire precautions

Improvements had been made to the fire containment and fire evacuation processes since the last inspection. Ear defenders had been purchased for residents who may find the noise of the fire alarm distressing, and rooms had been more clearly identified of residents who may refuse to evacuate. This would then be

communicated to the fire service as part of the centre's fire evacuation plan.

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 evacuation plan which outlined the supports they may require in evacuating. The person in charge amended these plans during the inspection to ensure they clearly reflected the evacuation needs of one resident.

The provider had a schedule of servicing for all fire equipment to ensure that it was in good working order. However, improvement was required to the record-keeping of such servicing records as not all records were available in the centre.

While fire containment had been improved in high-risk areas, there remained a number of fire doors without self-closures. These were detailed in a fire assessment improvement plan for the centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The provider had systems in place for the assessment of residents' needs and development of personal plans, to guide staff on how best to support residents. The provider had self-identified that improvements were required to the personal planning and goal planning processes with residents. For example, some improvement was required to ensure personal development goals were reviewed and updated in a timely manner. These were in progress at the time of the inspection. Detailed audits of care plans formed part of the quality improvement plan for the centre.

Residents' goal setting was also an important aspect of the care delivered to residents, with staff appointed as keyworkers with the responsibility for supporting residents to work towards achieving their chosen goals. These sessions were carried out using a person-centred approach where the input and decision-making of residents was prioritised as much as possible.

Judgment: Compliant

Regulation 6: Health care

Residents' healthcare needs were met through timely access to healthcare professionals and the ongoing monitoring of their healthcare needs. Residents had an annual review of their healthcare needs with their general practitioner (GP), and had access to a range of professionals such as a physiotherapist, optician, speech and language therapist, dentist and chiropodist. Regular reviews with allied

healthcare professionals had been facilitated, and healthcare plans were updated based on the recommendations made by professionals.

Where residents refused medical treatment, this was respected and explored through skills teaching and further education.

When residents had an identified healthcare need, these, for the most part, were supported by an appropriate plan of care. A number of care plans had been updated since the previous inspection, including high cholesterol and calcium deficiency. The inspector viewed a diabetic care plan and found it required additional details relating to normal values of blood sugar readings and the protocol to take if the readings fell outside of these values.

The inspector viewed a diabetic care plan and found it required additional details relating to normal values of blood sugar readings and the protocol to take if the readings fell outside of these values.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Overall, the provider promoted a positive approach in responding to behaviours of concern. On the previous inspection, it was found that the provider was required to review the arrangements in place in relation to restrictive practices and staff training in behaviour support.

The inspector found that staff had been provided with specific training relating to behaviours of concern or were booked onto training that would enable them to provide care that reflected evidence-based practice.

There was a small number of restrictive practices in place in the centre. The restrictive practices were supported by appropriate risk assessments, which were reviewed on a regular basis. Since the previous inspection, these had been reviewed by the restrictive practice committee. The inspector found further improvement was required in the approval and review process to ensure restrictive practices were the least restrictive and alternatives trialled were recorded. This was discussed with the management team at feedback.

Judgment: Substantially compliant

Regulation 8: Protection

It was considered that the residents were compatible with each other and enjoyed engaging in group activities in addition to their individual interests. Residents lived

with each other for many years, and there were no open safeguarding concerns at the time of the inspection. Each resident had their own bedroom, which had been personalised to their own taste. This promoted residents' independence and dignity and recognised their individuality and personal preferences.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to express their views in many ways, including day-to-day interactions and one-to-one key-worker meetings. In addition, residents were provided with weekly house meetings with their staff. Matters such as activities, menu plans, fire safety, respecting each other, and the complaints process, to mention a few, were discussed and decisions made. The inspector found that the rights and individual preferences of residents were respected and acted upon.

An example of this included the provider's surveying all residents' expressed interest in returning to day services when they had resumed after extended closures during COVID-19 restrictions. During this time, additional staff were placed in the house to facilitate all residents being at home during the day. The inspector learned that some residents had preferred to engage in centre-based and community-based activities and therefore did not want to return to formalised day service settings. Other residents wanted a mixture of both and therefore returned on reduced hours. Residents who missed their day services and wanted to maintain their previous attendance continued with their previous routines. By conducting these day programme preferences, residents were provided with individualised services based on their own expressed interests.

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	Compliant
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 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Liffey 6 OSV-0003921

Inspection ID: MON-0030979

Date of inspection: 29/06/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff are scheduled for necessary training, this includes Human Rights Training and Positive Behaviour Support. PIC continues to maintain a comprehensive training schedule and she reviews this and schedules staff into their training regularly.	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: A review of the chair purchase has occurred. Residents are provided with standard seating in communal areas by the service; if residents wish to buy themselves something additional such as an armchair that would generally be at their own expense. However, no evidence can be found of any consultation with the resident in question or the MDT, so there is no indication of their will and preference. This resulted in an unnecessary chair purchased that did not suit his needs. A full refund for this chair is being organized for the resident. We have also decided due to his replacement chair being something recommended by OT and in place to ensure his safety in the incident of a seizure, that we will also fully refund him for this second chair as it is a requirement rather than a discretionary purchase. The Contract of Care will be reviewed to ensure the above information is clear. A Liffey Procedure is being drafting in consultation with other PICs within the region outlining how residents, particularly ones with difficulty communicating their will and preference will be supported with purchases going forward. This will include documentation required to be kept and oversight of same.	

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Self-closers to be installed on the upstairs bedrooms of one house. Missing certificates for fire extinguishers have been requested from the relevant body and are now on file in the locations. Emergency lighting certs were available in the file on the day of inspection.	
Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: The resident in questions diabetic care plan has since been updated and includes information on what her normal blood sugar level readings should be and what to do if the level falls outside of this range.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: All staff within the team are scheduled to attend Positive Behaviour Support training sessions. The policy in place in SJOG is to use least restrictive option possible. Information has been lost along the way in relation to the rationale and options explored for one resident in relation to a restriction in place. A local operation procedure is being developed by the PIC to be reviewed by the Restrictive Practice Committee for the storage of such information. The restriction in question is deemed least restrictive as it means the resident is not interrupted at night by staff entering his room unnecessarily.	

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	08/12/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/01/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting,	Substantially Compliant	Yellow	15/01/2024

	containing and extinguishing fires.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	15/08/2023
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	18/10/2023