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

Issued by the Chief Inspector

Name of designated centre:	Tullycoora House
Name of provider:	Trinity Support and Care Services Limited
Address of centre:	Monaghan
Type of inspection:	Unannounced
Date of inspection:	04 March 2025
Centre ID:	OSV-0008059
Fieldwork ID:	MON-0046395

About the designated centre

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

Tullycoora House consists of a two storey large house with a wraparound garden and an additional apartment with a large back garden that can cater for one individual. The centre is in the countryside close to a nearby town. Facilities offered within Tullycoora House support residents to experience life in a home like environment and to engage in activities of daily living typical to those which take place in many homes, with additional supports in place in line with residents' assessed needs. Residents are support by a team of social care staff, team leaders and a person in charge.

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 4 March 2025	10:05hrs to 18:45hrs	Raymond Lynch	Lead
Tuesday 4 March 2025	10:05hrs to 18:45hrs	Karena Butler	Support

What residents told us and what inspectors observed

This risk-based inspection took place over the course of one day and was in response to a recent admission of a resident from another registered designated centre operated by the same provider. The resident made the transition to this designated centre following a number of safeguarding concerns and issues pertaining to risk identified on the inspection of their previous placement in January 2025.

This inspection was to review the actions taken by the provider in addressing those issues and to ensure the resident's current placement was effective in keeping them safe and meeting their assessed needs. It was also to monitor the designated centres level of compliance with S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the Regulations).

Residents appeared happy and content in their home on the day of this inspection and feedback from a family representative was positive and complimentary on the service provided. However, the governance and management arrangements required review to include the auditing systems so as to ensure, the service provided was at all times safe, appropriate to residents needs and effectively monitored.

Some improvements were also required with regard to the upkeep and maintenance of records in the centre and aspects of risk management required review. These are discussed later in this report.

At the time of this inspection, there were four residents living in the centre and the inspectors met with three of them over the course of the day so as to get their feedback and opinions on their home. (One resident was on a home visit on the day of this inspection). One inspector also spoke with one family representative on the day of the inspection (over the phone) so as to get their feedback on the service provided.

The centre comprised of a large detached two storey house in a rural location in Co. Monaghan. On the grounds of the property there was also a self-contained one bedroom apartment. Garden areas were provided to the front and rear of the property.

On arrival to the centre, the inspectors observed that the house was spacious, generally clean, warm and welcoming. The resident who had recently transitioned to the centre welcomed the inspectors into the house, smiled and said hello. The resident appeared in good form and was speaking with staff about things they wanted to do and places they wanted to go to later in the day.

One inspector went over to the apartment for a short period of time to see another resident. The resident appeared settled in their home and was relaxing on the couch. However, they chose not to engage with the inspector and this decision was respected. The inspector observed that staff were kind and caring in their interactions with the resident.

In the main house another resident was relaxing in their sitting room. They appeared in very good form, said they were happy in the house and that they liked to watch the football. One of the inspectors chatted for some time with this resident. The resident said they felt safe living in the centre and that if they were unhappy with anything that they would speak to the staff. They said that the staff were nice and they felt they had choices with what they did each day and what food they ate. They also said they had no concerns at this time.

Later in the day the resident who had recently transitioned into the centre invited the inspectors to see their room. It was observed to be decorated to their individual style and preference. For example, they had their own music system and microphone and enjoyed listening to music. They also had their own walk in wardrobe where they kept personal items, such as toiletries. When asked had they everything they needed they said "yes" and also said that they were happy in the house. They spoke about renewing their passport which they were doing on the day of this inspection and told one of the inspectors that staff were supporting them with this. The resident was observed to have a positive rapport with staff and told inspectors if they needed anything they could talk to any of the staff. Staff were also observed to calm, kind, reassuring and caring in their interactions with this resident. Inspectors observed a jovial interaction between the resident and the staff member whereby the resident informed the inspectors that they had a nickname for the staff member. Both the resident and the staff member laughed and then the resident fist bumped the staff member while smiling.

In the afternoon two of the residents wanted to go for a drive and visit Monaghan town. They told the inspectors that they were unsure if they would buy anything but wanted to browse the shops. They were looking forward to this trip and said goodbye to the inspectors before they left the house.

The two staff met with on the morning of this inspection (a team leader and a support staff) engaged with the residents in a friendly, positive and professional manner. They also demonstrated a good knowledge of the residents' assessed needs. The team leader spoke for some time to both inspectors about the residents' care plans to include positive behavioural support, medications and risk assessments.

The team leader explained that only one resident attended a day service which was for one day a week. Staff in the house provided a wrap around service to the other three residents (and also to the other resident when they weren't attending their day service). They also said that residents liked to go for drives, shopping and have a coffee out. In the evening time the two residents who went out shopping earlier in the day came back to the house. They told the inspectors that they had a good day and enjoyed their outing. On the day of this inspection, these two residents appeared to get on well together and both spoke positively about the staff team and their home.

One family member spoken with over the phone was also positive and complimentary about the service. They said that at this time, they were happy with the quality and safety of care provided in the centre and that their relative had everything that they needed. They also said that they could visit their relative whenever they wanted and that staff kept them updated on their progress. They reported that they felt the staff team were good and approachable. They believed that while their relative could have good and bad days, they were generally settled in the centre. When asked had they any complaints they said they had none at this time. They also mentioned that there had been a recent safeguarding incident in the service involving their relative however, they were satisfied in the way in which it was managed.

Overall, inspectors observed staff supporting the residents in a professional and caring manner at all times on the day of this inspection. They were attentive to the needs of the residents and residents were observed to be relaxed and comfortable in their home. Residents also appeared to enjoy being in the company of the staff team. Staff were also respectful of the individual choices and preferences of the residents and feedback from one family member on the quality and safety of care was positive and complimentary. The resident who had recently transitioned into the centre appeared to have settled in well and reported that they were happy there.

Notwithstanding, issues were found with the governance and management arrangements, upkeep of records and aspects of the risk management process.

The next two sections of the report outline the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of care provided to the residents.

Capacity and capability

While residents appeared happy and content in their home and spoke positively about the staff team and service provided, the governance and management arrangements required review. Additionally, the system with regard to updating and maintaining records kept in the centre also required review.

The centre had a clearly defined management structure in place which was led by a person in charge and a team leads. The person in charge was a qualified health/social care professional, demonstrated a knowledge of the residents' assessed needs and a knowledge of their legal remit to the Regulations.

A review of a sample of rosters from January to March 2025 indicated that there were sufficient staff on duty to meet the needs of the residents as described by the staff team and person in charge on the day of this inspection.

Staff spoken with had a good knowledge of residents' individual care plans. Additionally, from a sample of training records viewed, an inspector found that staff were provided with training to ensure they had the necessary skills to respond to the needs of the residents.

The provider had systems in place to monitor and audit the service. However this system required review due to a number of issues identified in this inspection and is discussed in greater detail under Regulation 23: Governance and Management.

Regulation 14: Persons in charge

The person in charge was responsible for the day-to-day operational management of two complex registered designated centres.

They were a qualified health/social care professional and on the day of this inspection demonstrated a knowledge of the assessed needs of the residents.

They appeared to understand their remit and responsibility to the Regulations. For example:

- they were aware of their legal remit to notify the Office of Chief Inspector of any adverse incident occurring in the centre in line with the regulations
- they also demonstrated a knowledge of the of the safeguarding procedures reporting processes.

Judgment: Compliant

Regulation 15: Staffing

From a review of a sample of rosters, speaking with two staff on duty and the person in charge, there were sufficient staffing on duty each day with required training to meet the needs of the residents as required.

One inspector completed a review of a sample of rosters from January to March 2025. This demonstrated to the inspector that safe minimum staffing levels were maintained in order to meet the assessed needs of the residents. The person in charge maintained a planned and actual roster that contained the full names and titles of staff that worked in the centre.

The centre required five staff positions to be filled in order to have a full staffing complement. The provider representative confirmed to an inspector that three staff were on-boarding with two due to start at the end of March 2025 and the other due to start in eight weeks. The provider was still actively recruiting for the remaining two positions.

In the meantime and as per the last inspection, the centre was heavily reliant on relief and agency staff to fill the vacant shifts required. While the provider was trying to ensure that it was the same relief and agency staff, it still meant that there was a large pool of people being required to fill vacant positions which could impact on the continuity of care provided to the residents. For instance, for the week of 24 February to 2 March 2025, 20 shifts were covered between seven relief staff and six agency staff. This is being actioned under Regulation 23: Governance and management.

Staff personnel files were not reviewed on this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

There were adequate arrangements in place to meet the requirements of this regulation. One inspector reviewed the training oversight document and a sample of certification or attendance records for between four to ten staff that included core staff and either agency or relief. In addition, that inspector spoke with the person in charge and one staff member in relation to training. From those conversations and reviews, the inspector observed that, the person in charge ensured that staff had access to necessary training and development opportunities. The provider had identified some areas of training to be mandatory, such as fire safety management and safeguarding. Staff had each received training in these key areas as well as additional training specific to residents' assessed needs.

For example staff received training in the areas of:

- medication management
- epilepsy and the use of emergency medication for epilepsy
- functionality capacity assessment
- Autism awareness
- human rights
- mental health awareness
- self-injurious behaviour
- positive behaviour support
- diabetes
- first aid
  - it was noted that one staff was due training in first aid; however, the person in charge confirmed they would not lone working until they were trained

Additionally, there were formalised supervision arrangements in place and from a review of one staff file and from speaking with the person in charge, supervision was occurring as per the frequency of the provider's guidance.

For instance, the supervision meetings that were reviewed were taking place every six to eight weeks and they provided an opportunity for staff to raise concerns if any.

Judgment: Compliant

Regulation 21: Records

Some healthcare/behavioural support related documentation required review to include:

- a blood pressure protocol required updating for one resident to reflect the findings/advice from a recent general practitioner (GP) visit
- some health assessments required review
- a positive behavioural support plan required updating to ensure that information with regard to when to use safe zoning was included
- another positive behavioural support plan required updating to ensure information included was accurate and applicable for the centre as it referred to a communication device that had never been in use in the centre
- one medication support plan for a resident still referred to them living in the centre they had moved recently moved from.

From a sample of two hospital passports, they required additional information or more elaboration. For instance, one hospital passport only stated a resident had epilepsy but did not elaborate of what type of seizures they may have or whether they could receive emergency medication for seizures. Another did not list on the resident’s medical conditions section that they had high blood pressure. This information was required to ensure hospital staff had the required information in order to appropriately treat the residents should they require hospital treatment.

One epilepsy care plan required further information in order to appropriately guide staff. For example, how frequently they get seizures or how long they typically last. While the plan did guide staff as to time frames of when to give emergency medication, it didn't elaborate on whether there was a specific seizure type the resident would have in order to administer the emergency medication. For example, was the medication to be administered for absent seizures as well as tonic clonic seizures. Also whether the medication was to be administered for cluster seizures.

Judgment: Substantially compliant

Regulation 23: Governance and management

While there were clear lines of authority and accountability in the service, the governance and management arrangements in place for this centre required an in depth review.

The designated centre was led by a person in charge who was supported in their role by an assistant manager, team leaders and a team of support/social care workers.

One team leader facilitated the earlier part of this inspection as the person in charge was not available at this time. They were a qualified professional who demonstrated a good knowledge of the assessed needs of the residents. They were also able to inform the inspectors of residents' care plans to include medication requirements, behavioural support and risk assessments.The person in charge was available to facilitate the rest of the inspection later in the morning.

The service was being monitored as required by the regulations however, the system of auditing and monitoring required review as the inspectors encountered a number of issues over the course of this inspection. Also, a number of documents provided to the inspectors on the day of this inspection were out of date.

For example, one inspector spent some time reviewing the Annual Review for 2024 (an important document which reviews the quality and safety of care provided in the centre to ensure it was in accordance with the regulations and standards). The document provided to the inspector did not meet the requirements of the regulations and this was brought to the attention of the person in charge. However, they said that the Annual Review had been updated and the inspector had been provided with an older version for review.

Another inspector requested a positive behavioural support plan for one resident. After reviewing it and noticing some issues, staff informed the inspector that they had not been provided with the most up-to-date version and a second one was presented. On review of the second plan it was also observed that this was one was again not the most up-to-date version and the inspector was then informed there was a third copy. However, this third copy was not presented to the inspector for review.

This was of concern to the inspectors as the centre was reliant on a number of agency staff to work with the residents (who may not be as familiar with their assessed needs as the core staff team). Taking into account residents' significant and complex assessed needs, it was important that all staff (to include agency and relief staff) had access to the most up-to-date and relevant information on the residents so as to ensure they had the most up-to-date knowledge to support them in line with their current care plans and assessed needs. Additionally, it was also important that older documentation where required was archived, so as this issue could not reoccur.

Inspectors also note that a number of audits on the centre required review. For example, one inspector reviewed the maintenance log/audit for the centre and could not ascertain from this document if some maintenance issues identified had been addressed. Some maintenance work was required in the apartment as far back as

2023, to include a new door handle, an update of the ventilation system and an issue with a tap. However, while the person in charge assured the inspectors these works had been completed, there was no date available on the log/audit as to when they were completed.

Additionally, on review of a quality enhancement plan it appeared that a number of actions identified were not being addressed in the agreed time frames as detailed on the document. The person in charge informed the inspectors that this was not the case and the actions had been completed in the agreed time frames. Again, this required review and was of concern to the inspectors as these documents were being presented as evidence of compliance with the regulations.

Some healthcare assessment forms required review. For example, on some of these assessments if was difficult to ascertain if the healthcare-related needs of the residents were being provided for. On one assessment it was recorded that the optical needs, speech and language therapy needs, dietary needs, psychiatry needs and mental health needs were unknown for a resident.

The person in charge informed the inspectors some of this was because they were waiting to get the residents bloods reviewed, the resident could refuse to co-operate with this procedure and could refuse to attend healthcare-related appointments. This was of concern to the inspectors as this resident had been living in the centre for some time and many of their health-related needs were recorded as unknown. The healthcare plan for this resident required more detail with regard to what actions the service was taking in order to address this issue. For example, more detail was required on how they were supporting the resident to attend medical appointments and avail of allied health care professional services (as detailed as being available in the centres statement of purpose)

In addition, one resident's healthcare assessment stated that the resident had a mental health related issue however, the person in charge confirmed this was not the case on the day of this inspection. This document needed to be updated.

There was a delay in referring residents to a speech and language therapist (SALT) with referrals made on 21 January 2025. Access to SALT could support the residents to communicate to the best of their ability so this delay was of concern to the inspectors. Additionally, this issue was actioned on the previous inspection of this service in July 2024.

A personal emergency evacuation plan for one resident required review and updating. It was important that this document was updated so as to ensure staff had the most up-to-date information on how to safely support the resident evacuate the centre during fire drills.

As identified in the last inspection, an inspector did not see evidence of alternative doors being used for evacuation purposes in order to assure the provider the residents could be evacuated from all areas of the centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed by the inspector and found to meet the requirements of the regulations.

It detailed the aim and objectives of the service and the facilities to be provided to the residents.

The person in charge was aware of their legal remit to review and update the statement of purpose on an annual basis (or sooner) as required by the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge was aware of their legal remit to notify the Health Information and Quality Authority (HIQA) of any adverse incident occurring in the centre in line with the Regulations.

Judgment: Compliant

Quality and safety

The residents living in this service were supported to live their lives based on their individual preferences and choices.

Residents' assessed healthcare-related needs were detailed in their individual healthcare assessments and from a sample of files viewed, they were being supported to attend GP and other allied healthcare professional services. It was identified that one resident's healthcare documentation required review and this was discussed under Regulation 23: Governance and Management.

Systems were in place to safeguard the residents and where or if required, safeguarding plans were in place. At the time of this inspection there were some open safeguarding plans in place in order to support residents' safety.

Systems were also in place to manage and mitigate risk and keep residents safe in the centre. However, the service was supporting residents that presented with complex behavioural issues and an aspect of the risk assessment processes required review.

Fire-fighting systems were in place to include a fire alarm system, fire doors, fire extinguishers, a fire blanket and emergency lighting/signage.

The house was found to be clean, warm and welcoming on the day of this inspection and laid out to meet the assessed needs of the residents.

While an issue was identified with risk management, this inspection found that the individual choices and preferences of the residents were promoted and residents appeared happy and content in their home.

Regulation 10: Communication

One inspector reviewed a sample of two residents' communication information. The inspector observed that, residents had documented communication needs in order to guide staff to understand how a resident may communicate and how staff can effectively communicate with them.

Plans included likes/dislikes, how the resident may demonstrate when they are happy or in distress and what triggers may cause them to become upset. In the case of one resident, their plan explained that if asked if they are happy they will say 'yes' or 'no' and that if they are not in a good mood that then they may laugh loudly.

Since the last inspection, staff had received additional training in relation to specific communication techniques used by residents, in this case a picture exchange programme. Additionally since the last inspection, more visuals were available in the centre to facilitate that picture exchange programme.

However, as per the last inspection, residents with communication difficulties had not been assessed by relevant professionals in order to assess their communication needs and supports they may require. This had the potential that not all of the residents' communication needs were familiar to staff to ensure that the residents could communicate appropriately and to promote effective communication. This is being actioned under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 17: Premises

The house was found to be spacious, clean, warm and welcoming on the day of this inspection. It was also laid out to meet the assessed needs of the residents.

Each resident had their own bedroom which was decorated to their individual style and preference. One bedroom has an ensuite facility and all three had walk in wardrobes.

Communal facilities included a large kitchen/cum dining room a sitting room, a living room, utility room, and a bathroom (one on the ground floor and one on the first floor). There was also a sleepover room and an office for staff use.

Garden areas are provided to the front and rear of the property for residents to avail of in times of good weather.

The apartment comprised of one bedroom, a wet room, a living area, a kitchen, a bathroom, and an office area.

Judgment: Compliant

Regulation 26: Risk management procedures

Systems were also in place to manage and mitigate risk and keep residents safe in the centre. However, the service was supporting residents that presented with complex behavioural issues and an aspect of the risk assessment processes required review.

Each resident had a number of individual risk assessment in their plans and where a risk was being identified, a number of control measures were in place to address it.

For example, where there was a risk of a resident presenting with behaviours of concern, the following controls were in place:

- 2:1 staff support was provided for where required
- staff had training in the management of challenging behaviour
- the resident had a positive behavioural support plan in place
- access to behavioural support was provided for.

Where there was risk related to using sharps the following controls were in place:

- sharps were kept locked in the office
- staff had training in first aid
- a sharps checklist was in place
- some residents were restricted from using sharps.

Where a resident was at risk of leaving the service unsupervised, the following controls were in place:

- 2:1 staffing cover where required, was provided for

- a missing person protocol was in place
- staff had access to a management on call system
- the centre had an electric gate.

However, an aspect of the risk management process required review. This was because the information on one risk assessment for the administration of emergency medication for a resident with epilepsy, was different to what was recorded in their care plan. This was of concern to the inspectors as it was important for staff to have the most up-to-date and correct information for the safe administration of rescue medication in the event of this resident having a seizure.

Additionally, the resident that lived in the apartment had a risk of presenting with significant behaviours of concern. This resident was staffed 2:1 during the day and 1:1 at night. After a serious incident of behaviours of concern, a recommendation was made in a 'learning incident/outcome form' that there should be two waking staff on night duty. However, this recommendation was not implemented. The person in charge explained to the inspectors that this recommendation was made by a staff member, had not been implemented and that the current 1:1 staffing arrangements in place at night-time was adequate. However, this information was not adequately documented on the form. For example, information on how the service had satisfied itself that the current staffing arrangements at night time in the apartment were adequate in managing the risks the resident presented with, had not been adequately recorded.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were suitable fire safety management systems in place, including detection and alert systems, emergency lighting and fire fighting equipment, each of which was regularly serviced. For example, the fire extinguishers, emergency lighting, and fire alarm were last observed to be serviced on 24 February 2025.

There were suitable fire containment measures in place as the doors in the centre and apartments were fire containment doors fitted with intumescent strips, cold smoke seals and self-closure devices. Staff had received training in fire safety and from a review of two residents' files there were personal emergency evacuation plans (PEEP) in place for residents. There was evidence of periodic fire evacuation drills taking place. An inspector reviewed the last four records of drills that had taken place and they included an hours of darkness drill that was required as an action from the last inspection. In addition, there was a schedule of fire evacuation drills to take place that was drawn up for 2025.

While one PEEP required further elaboration and evidence was required to ensure that the provider could evacuate residents from all areas of the centre, those issues are being actioned under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 6: Health care

Residents were being supported with their healthcare-related needs and had access to a range of allied healthcare professionals.

This included as required access to the following services:

- GP
- dentist
- medication reviews
- epilepsy reviews
- mental health reviews
- psychiatry

Additionally, each resident had a number of healthcare-related assessment forms and support plans in place so as to inform and guide practice and one staff spoken with was familiar with these plans.

It was observed that a some of the health assessment forms/documentation required review however, this was actioned under Regulation 23: Governance and Management and Regulation 21: Records.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where necessary, residents received specialist support to understand and alleviate the cause of any behaviours that may put them or others at risk. For example, from a review of two residents' files, one inspector found that residents had access to a behaviour support therapist and a clinical psychologist as required. There were behaviour supports plans in place were deemed necessary and those plans outlined strategies that staff needed to follow to support the residents. They included proactive and reactive strategies to guide staff on how best to support the residents.

One plan contained information regarding a communication device that was not in use with the resident since they moved to this centre. Another plan did not include information with regard to restrictive practices of locking doors when they are upset. Those identified issues were actioned under Regulation 21: Records.

As an action from the last inspection, one resident's behaviour support plan was since reviewed by a behaviour therapist to include support strategies on how to support them with coping strategies for engaging in activities in the community.

An inspector observed that the window restrictors that had been in place at the time of the last inspection in two rooms that were not required for the assessed needs of the residents had since been removed.

Judgment: Compliant

Regulation 8: Protection

One resident had recently transitioned into this service. A number of peer-to-peer related issues had been identified in their previous placement and steps had been taken to address those issues. However, as the resident was now residing in this service, those peer-to-peer related safeguarding concerns were no longer an issue.

Additionally, policies, procedures and systems were in place to safeguard the residents and where or if required, safeguarding plans were in place. At the time of this inspection there were some open safeguarding plan in place for the residents.

However, one of the inspectors observed that the issues had been escalated to management and the designated safeguarding officer, the national safeguarding team had been notified and, the Office of the Chief Inspector also notified.

The person in charge also explained to an inspector that all allegations of abuse were recorded, reported and managed in line with the safeguarding policy and where required, safeguarding plans were implemented.

The inspectors also noted the following:

- two staff spoken with said they would have no issue reporting a safeguarding concern to the person in charge if they had one
- two residents spoken with said they were happy with the service and would speak to staff at any time if they had any issues
- the two residents were also observed to be relaxed and comfortable in the company and presence of the staff team
- residents also appeared to be good self advocates. For example, on the day of this inspection one resident was discussing an issue to do with their finances with the designated safeguarding officer and provider representative
- one family member spoken with over the phone on the day of this inspection was positive and complimentary about the service provided and said they had no complaints at this time. They also said that there had been a recent safeguarding issue which involved their relative however, they had been notified of this by the person in charge and were satisfied at they way in which the issue was being managed
- safeguarding was discussed with staff at team meeting as was advocacy and the complaints process

- staff had training in safeguarding of vulnerable adults
- information on safeguarding was readily available in the centre
- the resident who had recently moved into the service had recently completed a capacity assessment and been provided with education on relationships.

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	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Tullycoora House OSV-0008059

Inspection ID: MON-0046395

Date of inspection: 04/03/2025

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 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Resident's blood pressure support plan has been reviewed and updated to include the findings from the GP appointment, this has also been reflected on their health action plan and pre and post consultation form.

Health assessments are currently under review and for one resident we are currently waiting for medical records to be issued by his general practitioner. This will be completed by 30/04/2025.

One resident's Positive Behaviour Support Plan is currently being reviewed and updated by our Positive Behaviour Support Specialist and Clinical Psychologist with input from the Centre staff. Completion by 30/04/2025

One resident's Positive Behaviour Support Plan Positive Behaviour Support Plan is currently under review to explore object reference communication, this will be updated by 30/04/2025.

The medication support plans have been reviewed and updated as of 05/03/2025, and will be reviewed monthly by the PIC as part of their Centre auditing.

All residents' Hospital Passports have been reviewed and updated to elaborate on current medical conditions and communications 10/03/2025

Awaiting a Neurologist appointment review to seek further input on the administration of emergency epilepsy medication and if the medication can be administered in the event of cluster seizures either absent or tonic colonic this will be completed by 30/04/2025

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A review of the Person in Charge structure has been undertaken, where the Person in Charge will have Person In Charge responsibility over this one Centre instead of two. A notification will be submitted to HIQA by 30/04/2025.

A Team Leader checklist has been created to ensure that the most up to date and accurate information is available in the Centre. This is reviewed daily, by the Person in Charge and checked by the Assistant Director during their weekly visits. A Clinical Quality Assurance Manager has also been appointed who will work as part of the senior management team in ensuring the Centre is compliant.

The Quality Improvement Plan has been reviewed and actions completed have been closed and moved to the closed section of the report. The Quality Improvement plan continues to be a live document with any audits or visits carried out in the designated Centre and actions identified are reflected on the Quality Improvement Plan and reviewed by Assistant Director and Director of Operations & Governance. A Clinical Quality Assurance Manager has also been appointed who will work as part of the senior management team in ensuring the Centre is compliant.

Weekly Service Audits continue to be completed, which are sent to the Director of Operations & Governance, and the Registered Provider Representative to review and make comment on.

The Maintenance Log had been updated before the end of the inspection and sent to the Person in Charge by the Facilities Manager. This is now accessible via the Health and Safety folder within the Centre.

The most up to date Regulation 23 audit that had been reviewed and amended following the previous inspection in July 2024, this is available within the Centre for visitors and staff to access.

One resident’s Positive Behaviour Support Plan Positive Behaviour Support Plan is currently under review to explore object reference communication, this will be updated by 30/04/2025

Escalation of SaLT referrals have been made privately through Trinity SCS due to the waiting times, to ensure the residents that require this input receive an assessment as soon as possible to aid the staff with their communication needs will be completed by 16/05/2025.

A further Occupational Therapy referral has been made for one resident to establish a sensory assessment to meet his current sensory needs will be completed by 16/05/2025.

A review of health documentation is underway for one resident with the support of their clinical nurse specialist to review the reports issued in relation to mental health services as a difference of opinions had been identified by two external professionals this will be completed by 30/05/2025.

PEEPS for all residents have been reviewed as of 03/04/2025, the PIC will continue to keep these under review based on the assessed needs of residents.

A fire drill has been carried out with all residents on the 08/03/2025, with a scenario that included the front door not being accessible where all residents had to exit the back door to assembly point. The evidence of this can be found in the fire folder within the Designated Centre.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Residents risk assessment relating to epilepsy have been reviewed to reflect the information detailed within the care plan, this was completed on the 10/03/2025

The incident report referred to in the report has been updated to reflect that adequate staffing arrangements are in place within the Centre, based on the assessed needs of residents.

Support provided to each resident is reviewed on a daily and ongoing basis through daily notes recordings, which reflects the residents care/health/positive behaviour support plans and risk assessments.

Risk assessments continue to be reviewed as part of the Assistant Director's audits and during visits to the Centre.

Weekly service audits carried out in the Designated Centre capture the review of risk assessments and identify when they may need reviewed or updated.

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 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	30/04/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/05/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Substantially Compliant	Yellow	30/04/2025

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			