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 8
Name of provider:	St John of God Community Services CLG
Address of centre:	Dublin 8
Type of inspection:	Unannounced
Date of inspection:	22 November 2023
Centre ID:	OSV-0008307
Fieldwork ID:	MON-0041964

About the designated centre

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

Liffey 8 is a designated centre operated by St. John of God Community Services CLG. The centre located on the provider's campus setting in Islandbridge. Residents in Liffey 8 have a moderate to profound intellectual disability and have support needs in the areas of behaviours of concern, sensory needs, communication and specific dietary requirements. Residents are provided with their own bedroom, living room and kitchen as well as a small courtyard and are supported to access facilities in the community as well as those available on the provider's campus. Residents have access to multi-disciplinary allied professionals through the provider's own clinical team as well as community allied health care professionals. The centre is staffed by a team social care workers who report to the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Wednesday 22 November 2023	10:00hrs to 16:15hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This inspection was an unannounced inspection which was carried out in response to the receipt of unsolicited information regarding the quality and safety of care in the centre. The inspection took place over one day and the inspector had the opportunity to meet all of the residents. Overall, it was found that the oversight arrangements in the centre were not effective in ensuring the delivery of safe care to the residents.

The designated centre is located on the provider's campus in Islandbridge. It is made up of two small houses and is home to three residents. These residents had recently moved from a larger congregated setting into the two smaller houses that made up the designated centre. The inspector used a walk-around of the premises, observations of care and support, and conversations with staff and managers to inform judgments on the quality and safety of care.

The inspector first visited the single occupancy home. The inspector was greeted by a staff member on arrival. They informed the inspector that they were a relief staff but had worked a number of shifts in the centre and were familiar with the resident and their assessed needs. They spoke about the plan of activities for the day and described the resident's preferences and communication style. The staff described the resident's behaviour support needs and their specific dietary requirements and were informed regarding these. However, the staff member said that they had not received a formal induction and were not familiar with some control measures in place to mitigate against risk in the centre. For example, they did not know where the fire panel for the centre was located.

The inspector saw that the centre was clean and generally well-maintained. The resident was dressed, ready for the day and was completing a jig-saw puzzle in their sitting room. They appeared relaxed and comfortable and communicated that they did not wish to engage with the inspector. Later in the day, the inspector heard this resident singing along to music and saw that they were supported to go for a walk in the local park with staff. The inspector heard staff communicating with the resident in a kind and gentle manner.

The staff member showed the inspector photographs of recent outings that the resident had gone on, including a holiday to Belfast and trips to a local hotel for a drink.

The person in charge and service manager made themselves available on the morning of inspection and spoke about the positive impact that the smaller designated centre was having on the quality of life for residents. This included a generally quieter living environment and increased opportunity to participate in community outings and holidays. The service manager described how an overnight holiday for one of the residents was a big achievement for this resident and for the

staff team who supported them.

The second house the inspector visited was home to two residents. The inspector was told that these residents usually accessed day services. On the day of inspection, one resident had a medical appointment and they were supported to attend this appointment by the person in charge. The other resident attended day service as per their usual routine. The inspector met both of these residents at the end of the inspection. They appeared to be comfortable in their home and were relaxing in their sitting room on their return from day service.

A walk-around of both of the houses was completed. They were both seen to be generally clean and well-maintained however, there were some areas for upkeep. These will be discussed in the quality and safety section of the report.

The inspector met with the service manager and discussed the staffing level arrangements in the centre and the impact that this was having on the quality and safety of care provided. The service manager acknowledged that there were gaps in the roster which were required to be filled by relief and agency staff. While there was a preference for familiar relief staff, this was not always possible, and had resulted in some incidents of concern. For example, the service manager spoke about an occasion whereby a resident engaged in self-injurious behaviour due to the presence of an unfamiliar staff. The inspector reviewed the rosters for the centre and saw that there was a high reliance on relief and agency staff. This was not supporting continuity of care and will be discussed further in the capacity and capability section of the report.

The inspector spoke to the person in charge who informed her that, although they were employed as a full-time person in charge for this designated centre, they were also required to assist in an administrative capacity with another designated centre. This was found to be impacting on the oversight arrangements for the centre. For example, the inspector observed a number of risks on the day of inspection which the person in charge and service manager were not aware of. These included an inactive fire panel and a lack of guidance and local operating procedures for staff in the management of risks in the centre. These will be discussed further throughout the next two sections of the report.

The inspector was told that residents had moved to two smaller houses in order to provide better quality and more individualised care. While there were gentle and person-centred interactions occurring in the centre, there were also a number of deficits noted in the quality and safety of care provided to residents which required review and improvement by the provider.

Overall, the inspector found that, while the residents were living in homes that were clean and generally well-maintained, there were enhancements required to the oversight arrangements to ensure that care was being delivered in a safe manner.

The next two sections of the report will describe the governance and management arrangements and how these impacted on the quality and safety of care.

Capacity and capability

This inspection was carried out in response to the receipt of solicited and unsolicited information received regarding the quality and safety of care in the centre and to monitor the ongoing levels of compliance with the Regulations.

This designated centre had been registered for approximately one year at the time of inspection. Previous inspections, including a site visit and a short-notice announced inspection had identified that there were areas of non-compliance including in staffing, premises and fire precautions. The provider had committed to addressing these risks through their compliance plan. However, the current inspection found that some of the provider's measures to address non-compliance were ineffective or were not sustained. Furthermore, the oversight arrangements were ineffective in ensuring that residents were in receipt of safe care from a stable staff team.

The provider had appointed a person in charge for the centre however, the inspector found that they were not available to the centre in a full-time capacity and in line with the statement of purpose. This was impacting on the oversight of care.

A number of areas of non-compliance were identified on the day of inspection, for example, staff practices were observed which were not in line with best practice or appropriate to meet the needs of the residents. There was a failure of the provider to effect robust local management arrangements to ensure the delivery of safe and effective care.

The provider had failed to take timely action to address some known risks in the centre which they had self-identified through their own provider-led audit arrangements. For example, an audit completed by the provider in early October 2023 had identified that rosters were not accurately maintained and that new staff were not in receipt of inductions. Actions had not been implemented to address these by the time of the inspection and the inspector saw that there remained issues with the maintenance of rosters and with the induction of new staff.

The rosters in the centre were not maintained in a consistent manner to enable the inspector to verify when the person in charge was working and which relief staff covered shifts. There were gaps observed in rosters over the preceding weeks where it was not clear which relief staff had worked a particular shift. Additionally, there were two copies of a roster maintained for one week in November. Each copy varied slightly and it was not readily apparent which roster was the actual roster.

The inspector was told that there were vacancies in the centre and that this resulted in a reliance on relief and agency staff to fill the gaps created by these vacancies. The provider had endeavoured to source consistent relief staff however this was not always possible and the rosters showed that there remained a high number of relief staff filling shifts. This had also been a finding on the most recent previous

inspection of the centre in February 2023.

The provider had committed to implementing an induction process for all new staff subsequent to the last inspection of the designated centre. While an induction folder was in place, the inspector saw that no inductions had been completed with new staff since July 2023 despite a high number of relief and agency staff working in the centre since then.

The heavy reliance on relief staff and the lack of an appropriate induction was resulting in negative outcomes for residents and gaps in the oversight of the day-to-day delivery of safe and effective care.

For example, on one occasion, a number of days before the inspection, it was documented that a resident engaged in self-injurious behaviour due to the presence of an unfamiliar staff member. While support was provided to the resident to de-escalate, this support was provided by a staff who was known to the resident but who did not normally have responsibility for the delivery of direct care and support. This staff had not received the required training in areas such as positive behaviour support as this type of direct care did not form part of their typical duties.

In addition, some relief staff on duty told the inspector that they had not received a formal induction which impacted on their knowledge of the centre and its overall operation, for example, they did not know the location of the fire panel in the centre which, in turn, resulted in them not identifying that fire panel was not working on the day of inspection, a matter that was identified by the inspector and brought to the attention of the provider.

Regulation 14: Persons in charge

The provider had appointed a person in charge for the centre who worked in a full-time capacity.

The person in charge appointed met the requirements of Regulation 14 in relation to management experience and qualifications.

However, the provider had not made appropriate arrangements to ensure the person in charge could fully carry out their regulatory and management duties for the centre.

The inspector was informed that the person in charge had been assigned additional administration duties for another of the provider's designated centres and worked in that location, on average, two days per week.

This meant that the person in charge was not available to the designated centre on a full-time basis. This arrangement resulted in reduced oversight of the current designated centre. This was found to be impacting on the quality and safety of care.

The hours that the person in charge worked in the designated centre were not recorded on the roster and the inspector could not verify the number of hours that the person in charge was available to the centre.

The inspector was informed verbally by the provider that this arrangement would cease on the day of inspection and that the person in charge would be made available to the centre on a full-time basis going forward.

Judgment: Substantially compliant

Regulation 15: Staffing

There were 1.5 whole time equivalent (WTE) vacancies across the designated centre which equated to two staff members. Additionally, there was a 0.2 WTE gap in the roster for one of the houses which had not been set out as a vacancy. Due to this gap, there was one shift a week in this roster for which a relief or agency staff was consistently required. This arrangement was not supporting continuity of care for the residents.

The inspector saw that there was a high reliance on relief and agency staff to fill gaps in the roster due to these vacancies and staff members' planned leave. The provider endeavoured to source consistent relief and agency staff to support the residents and the inspector saw that some relief and agency staff had completed several shifts in the centre. However, overall the contingency arrangements were ineffective in ensuring continuity of care.

The frequent use of unfamiliar staff was found to result in negative outcomes for residents. For example, one resident engaged in self-injurious behaviour in early November 2023 due to the presence of an unfamiliar agency staff. The resident was required to be supported for a short period on this day by a staff who was familiar to them but who was not trained or suitably qualified to meet the resident's needs. The inspector was told that this arrangement was maintained for a number of hours until a familiar and suitably qualified relief staff could be sourced.

Rosters in the designated centre were reviewed and were found not to be maintained in line with the requirements of the Regulations. There were gaps in the rosters whereby the relief or agency staff were not named. Therefore, it was difficult at times to verify who had completed shifts in the centre.

Judgment: Not compliant

Regulation 23: Governance and management

The designated centre was not effectively resourced to ensure the delivery of safe

care. Additionally, the management systems were ineffective in ensuring that the service was safe and consistently and effectively monitored. The staff team were required to complete local audits including, for example, fire safety audits and water flushing schedules. The inspector saw that these audits did not identify issues that were presenting a risk to the delivery of safe care including risks relating to the fire panel and the water temperature in the centre.

The provider had completed a six-monthly unannounced visit of the centre. This audit was comprehensive and identified a number of risks and areas of non-compliance including deficits in the oversight arrangements. For example, the six-monthly audit highlighted that the management structures in the centre were not clearly defined and, that there was confusion regarding who was the appointed person in charge at the time of the audit. The audit also identified the need for induction forms to be completed for new staff and found that there was a failure to name agency and relief staff on rosters. However, timely action was not taken to address these risks and many of them remained outstanding at the time of inspection.

The provider had not ensured that the person in charge had sufficient time and resources to implement the actions, as they were also required to work in another centre in an administrative capacity for some of their contracted hours.

Areas of non-compliance had been identified on previous inspections of the centre and the provider had committed to addressing these through their compliance plan submitted to the Chief Inspector. However, the inspector saw that some of these actions had not been completed or were not sustained. For example, the provider had committed to implementing an induction folder to ensure that all new and unfamiliar staff were inducted to the centre and were made aware of the residents' needs. While induction forms and a folder were available in the centre, the inspector saw that only two new staff had completed an induction in spite of a high number of other relief and agency staff working in the centre.

The inspector found that, while the relief staff on duty were aware of the residents' assessed needs and were providing care in a kind and person-centred manner, they were not familiar with the risks in the centre and the measures in place to control for these. For example, staff on duty were not informed of the location of the fire panel. There were also practices observed during the day which the provider was not aware of and had not risk assessed. For example, staff on duty were seen using the facilities in a neighbouring designated centre which meant that a resident was left unsupervised for a short period of time. While the management team expressed that this should not be the practice, there were no local operating procedures to guide staff in what the practice should be.

The roles and responsibilities of all staff were not clearly defined and there was an absence of local operating procedures to guide staff in managing specific risks. For example, it was not clearly established who maintained responsibility for inducting new staff. Additionally, there was an absence of local operating procedures to guide staff in relation to comfort or mealtime breaks while lone working in the centre.

Judgment: Not compliant

Quality and safety

This section of the report details the quality and safety of the service for the residents who lived in the designated centre. Overall, the inspector was not assured that residents were in receipt of a safe service. In particular, improvements were required to the fire detection arrangements and to the management of risk.

The inspector saw that the premises of both of the houses were clean and tidy. The premises were also generally well-maintained however, there was some upkeep required including to the doors and windows of the houses. Some of the premises issues such as the lack of hot water in a kitchen and bathroom tap were impacting on the infection prevention and control (IPC) measures in the centre, this was addressed by the provider's maintenance team on the day of inspection.

Residents appeared to be comfortable in their homes and were observed coming and going to day services, to medical appointments and to access their community throughout the day. The inspector saw photographs of residents engaging in community activities and was told that one resident had recently achieved a goal of going on an overnight holiday.

However, overall there were a number of risks which were impacting on the delivery of safe and effective care to the residents. Some of these risks had been identified on the last inspection of the centre and the inspector found that the provider's measures to address these risks had been ineffective. For example, the inspector found on the last inspection that a fire panel had not been installed in one of the houses of the designated centre. The inspector saw on this inspection, that while a panel had been installed, it was not working on the day and did not appear to be connected to the mains electricity supply.

An immediate action was issued by the inspector to the provider requiring this matter to be addressed immediately and for the provider to give assurances that all suitable fire safety arrangements were in place within a short time frame.

A contractor attended the centre and assured the inspector that the fire alarms were working and were connected to the designated centre located next door. Assurances were provided that while the panel was not working, the panel in the centre next door would be activated and that the alarms in both designated centre would sound in the event of a fire.

There were a number of other risks observed by the inspector on the day of inspection. Many of these were not known to the provider however, in discussion, the service managers set out that these practices would not be in line with their policies or procedures. The inspector found that there was a lack of documented local operating procedures to guide staff in the management of risks. For example,

inconsistent practices were seen in relation to staff taking comfort breaks. Additionally, some of the control measures implemented to mitigate against specific risks were ineffective. For example, new staff were required to complete an induction. However, there was no clear guidance to determine who was responsible for inducting new staff and the inspector saw that this induction was frequently not completed.

Improvements were also required to the storage and recording of medications. While the inspector saw that medications were administered as prescribed, there was one medication which was not stored in line with best practice and improvements were required to ensure that all PRN (as required) medications were accurately recorded.

Regulation 17: Premises

The inspector completed a walk around of both houses that comprised the designated centre. The inspector saw that the houses were clean and were generally well-maintained. There was adequate private and communal space as well as facilities for cooking and laundering clothes.

However, the provider's arrangements to ensure appropriate ongoing management of the premises and upkeep required improvement and enhancement to ensure all maintenance matters were identified and addressed in a timely manner.

Some of the issues set out below were addressed on the day of inspection as a result of the inspector bringing these matters to the attention of the provider.

For example:

- The front doors of both houses had not been replaced. The provider had committed to replacing these doors by 30 June 2023 in the compliance plan submitted subsequent to the last inspection of the designated centre.
- There was no hot water in one of the house's kitchen and bathroom taps and the water pressure was found to be very low. The lack of warm water was leading to an infection prevention and control (IPC) risk as staff stated that they routinely washed dishes with cold water and washed their hands in cold water. This was addressed by the provider's maintenance team on the day of inspection.
- The toilet in one designated centre did not flush. This was also addressed by the provider's maintenance team on the day of inspection.
- Some of the windows in one of the houses did not close properly and were observed to be draughty.
- The frames of some of these windows were damaged and required repair
- The bathroom floor in one of the houses was peeling away from the wall and presented an IPC risk

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The systems in the centre for the assessment and management of risk were ineffective. A number of risks were identified on the day of inspection. Some of these were not known to the provider and there were no risk assessments or guidance for staff on how to control for them. These included:

- the supervision of residents when lone working staff required comfort or lunch breaks
- fire safety risks including the inactive fire panel
- Infection prevention and control risks including the lack of hot water in taps

The control measures in place to mitigate against known risks were ineffective in some instances. For example, the procedure to ensure that new or relief staff were inducted was not implemented consistently or effectively.

The systems for responding to emergencies were also not clearly defined or were ineffective. For example, during an incident of self-injurious behaviour by one resident, the provider relied on a staff who was not suitably qualified to de-escalate this behaviour and to support the resident.

The bus which was used by the residents in this centre was seen to be dirty and there was some observable damage on the exterior, for example the vehicle had a green substance covering the roof.

The inspector saw that the front bumper was damaged and there were a number of dents and scrapes to the side of the bus that had rusted. The vehicle's National Car Test (NCT) certificate had also expired.

Judgment: Not compliant

Regulation 28: Fire precautions

The provider had installed an additional fire panel in one of the houses subsequent to the last inspection of the centre.

However, on the day of inspection the fire panel was not working. In addition, the fire panel was ticked, on an internal audit, as having been routinely checked. However, the inspector was not assured that these audits were completed accurately as the panel was inactive on the day of inspection and staff spoken with did not know where to locate the fire panel.

The inspector asked the service manager if they could activate the panel however, they were unable to do so.

The inspector took the unusual step of issuing a verbal immediate action to the provider requiring them to provide assurances that the fire detection system was working and that the alarms would activate in the event of a fire. The provider contacted a fire services engineer to the centre on the day of inspection to review the matter.

An assurance was provided, before the close of the inspection, which set out that there were suitable arrangements for the detection and alerting in the event of a fire. However, the additional fire panel remained inactive as more comprehensive works were required to ensure it became operational.

Judgment: Not compliant

Regulation 29: Medicines and pharmaceutical services

Records of medications prescribed and administered were maintained in the centre. These were reviewed and it was found that medications were administered by a suitably qualified staff and were administered as prescribed. Some improvements were required to the recording of PRN medications to ensure that the time of these was accurately recorded.

Medicines were seen to be generally stored appropriately. One medication, an antiseptic, was stored in a specimen jar with a resident's name hand-written on the front. It was not clear who had prescribed this, what the medication was for or when it had been first opened and was to be used by.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Staff in this centre had received training in crisis prevention interventions (CPI) however they had not received training in positive behaviour support. The inspector was informed that four staff were due to receive this training in the coming weeks however there was no date determined for when all staff would be trained.

Some residents had positive behaviour support plans on their files. These were seen to be very detailed and provided a very comprehensive overview of the support arrangements required for residents in terms of their behaviour support needs. Staff were seen supporting the residents in line with their behaviour support plans and were aware of their behaviour support needs and de-escalation strategies.

However, improvements were required, given the high number of unfamiliar staff working in the centre, to ensure that positive behaviour support plans were clear and concise.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant

Compliance Plan for Liffey 8 OSV-0008307

Inspection ID: MON-0041964

Date of inspection: 22/11/2023

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 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: As of 22/11/23 the PIC is exclusively based in this DC only.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: There is 0.2 vacancy in one house of the designated center and this has been filled WC 11.12.2023 Recruitment is ongoing for the remaining 1.5 WTE vacancy (1 RN and 0.5 SCW). This will be filled as soon as possible with a target date of 30.04.2024. Approval has been sought to seek derogation from the HSE in order to recruit. Interviews are scheduled for January 2024 While the recruitment is ongoing, we have secured a relief staff to exclusively cover the vacant shifts in the apartment. We are also using consistent relief / agency staff in the other house. The staff roster is now reflecting the regulatory requirements and the PIC hours are included on same	
Regulation 23: Governance and	Not Compliant

management	

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC is on site Monday – Friday to support the Team and residents. The PIC is also supported by the PPIM who is based on site also.
There have been more robust systems put in place to ensure audits are carried out and actions are identified, with a plan for completion of same. Actions identified from any audits are added to the QEP.
The QEP is reviewed monthly at the DC meeting by the program manager, PPIM and PIC to monitor the progress of actions towards completion.
Guidance by means of Local Operational Procedures in relation to comfort breaks, Lone working and induction of new staff have been put in place.
The PIC has assumed responsibility for staff inductions. Out of hours inductions will be completed by staff and followed up by the PIC on her return to duty. Staff have written guidance to support them in completing this.
All the above actions are in place from 14.12.2023

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. The organisation has received quotes for the replacement of the doors to both units. This will be actioned in Q1 of 2024.
2. Privacy blackout coating and blinds are being sourced for the door to the single occupancy unit to provide privacy in the interim. This will be complete by 31.01.2023
3. All maintenance issues have been logged on the EMaint system with a target completion date of 31.01.2024
4. Dishwasher will be installed by 31.01.2024
5. Kitchen sink is not a designated sink for hand hygiene. Signage is in place to remind staff and this has been discussed with all staff in the designated centre at a meeting on 14.12.2023
6. There are 4 windows which show signs of damage. Quotes are currently be sought for replacement of these windows. The damaged windows will be replaced by 31.03.2024
7. The flooring in the bathroom will be repaired by 31.03.2024

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk

management procedures:
1. LOP in place for comfort breaks, Induction and lone working. Risk assessments are also in place as of 12.12.2023
2. Fire risk assessment is in place in relation to the repeater fire panel in the apartment of Liffey 8. The fire detectors have been operational at all times.
3. The hot water to the kitchen sink in the sole occupancy unit has been fixed as of 22.11.2023
4. There is a detailed induction plan and procedure in place with an LOP to guide staff from 14.12.23
5. Both vehicles on site have valid NCT certs to 04.24 and 09.24 respectively.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
There is a risk assessment in place regarding the fire panel and evacuation. All alarms are working appropriately, and staff are advised to evacuate when same are activated.
The contractor has been contacted regarding the repeater fire panel, a risk assessment is in place regarding the inactive repeater fire panel and all staff are aware of this. A replacement repeater fire panel is ordered.
Fire detectors at this location were working at the time of the inspection, the issue was with the fire repeater panel which is due for replacement and is on order.
Weekly checks are in place by PIC regarding internal audits and tick charts
All current staff have been inducted to local fire procedures, there is a form which is located in the induction folder for new staff.
All above actions are in place from 14.12.2023

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
Medication audits have been completed. All medications without appropriate label have been removed. Staff are aware that these cannot be kept on site following a meeting on 14.12.2023

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
4 staff have completed Positive behavior support training, the 4 remaining staff are booked to receive this training in the first quarter of 2024 and this will be completed by 31st March.
PIC has linked with behavior support specialist for a more accessible version of the behavior support plan. This was completed 14.12.2023
Revised behaviour support plan will be completed by 31.01.2024
The single occupancy unit has a full complement of staff

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 14(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.	Substantially Compliant	Yellow	22/11/2023
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/04/2024
Regulation 15(3)	The registered	Not Compliant		14/12/2023

	provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.		Orange	
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	14/12/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	28/02/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	14/12/2023
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management	Not Compliant	Orange	14/12/2023

	structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
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	14/12/2023
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	14/12/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Not Compliant	Red	31/01/2024

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 26(3)	The registered provider shall ensure that all vehicles used to transport residents, where these are provided by the registered provider, are roadworthy, regularly serviced, insured, equipped with appropriate safety equipment and driven by persons who are properly licensed and trained.	Not Compliant	Orange	14/12/2023
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	14/12/2023
Regulation 28(3)(b)	The registered provider shall make adequate arrangements for giving warning of fires.	Not Compliant	Red	22/11/2023
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing,	Substantially Compliant	Yellow	14/12/2023

	storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	31/03/2024
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	31/03/2024