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:	Bower House
Name of provider:	Dundas Unlimited Company
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	20 March 2025
Centre ID:	OSV-0005608
Fieldwork ID:	MON-0046404

About the designated centre

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

Bower House is a community-based respite service for up to six male or female adults with an intellectual disability. It is situated on the north side of Co. Dublin within walking distance of a local village and its amenities such as shops, cafés, restaurants, and a shopping centre. The centre is close to public transport links including a bus and train service which enable residents to access neighbouring areas. The building is a large, two-storey house in a coastal area of Dublin county. There are six private bedrooms for residents, and three shared bathrooms, two with a bath and shower. The kitchen is domestic in nature and residents are encouraged to participate in grocery shopping and the preparation of meals and snacks. There is one dining room, one living room and two sitting rooms in the house. The property is surrounded by a large garden. Staff encourage residents to partake in activities in the local community. The staff team comprises a person in charge, staff nurses and direct support workers and a household staff. Staffing resources are arranged in the centre in line with residents' needs.

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
Thursday 20 March 2025	10:30hrs to 19:30hrs	Gearoid Harrahill	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet the residents who were using this designated centre for their respite breaks. The inspector also spoke with family members and staff, observed support delivery during the day, and reviewed documentary evidence as part of the evidence indicating experiences in this designated centre.

On arrival, the inspector observed that residents were attending their day services, and one resident was ready to be collected as they came to the end of their respite break. The inspector chatted with this resident about what they had enjoyed doing during their stay, and if they liked the centre, staff team and activities here. Staff supported the resident to tell the inspector what they had been doing, and the resident gave the inspector a big smile and a thumbs-up. The inspector met with other residents as they arrived in the afternoon. One resident was watching cartoons and had brought a collection of DVDs with them to the centre. They enjoyed singing and speaking along with their favourite shows.

The staff were aware of one resident's preferred routine when they returned home, and had their dinner, snacks and computer setup ready for them on their return. This resident did not wish to have others in the room for long and this was respected as they watched videos online. The inspector observed conversations between a front-line staff member and a resident who used non-verbal means of communication. The staff spoke along with what each gesture meant and replied back with some gestures of their own, indicating to the resident that they understood what the resident was saying to them. This was used to confirm what they wanted to do in the evening and what they wanted for dinner, and the resident appeared happy with this. The inspector discussed care and support plans with front-line staff, and in the main, they were familiar with where to find guidance on resident support and were observed delivering in line with their relevant plans. Staff retained body charts for residents who presented with injuries during their respite stay, including one resident seen with bruises during the inspection, however it was not clear how other parties such as day service were being engaged with to establish cause when the staff team did not observe the potential cause themselves.

The annual report for 2024 included pictures of residents enjoying activities and outings in their community, including going to the beach, going bowling or to the arcade, or making pizzas in the house kitchen. This report collated quotes and commentary from residents and their families. Residents commented that they "like staff" and that "they're mad" and "are nice and help me". The provider noted where residents smiled or nodded when asked if they liked aspects such as meals and outings. Some residents commented that they would like more trips out during their stay, and others said they liked to go shopping, walk on the nearby beach, do arts and crafts, and watch movies together. An action for 2025 was maximising the use of resident feedback to enhance variety of ideas for things to do when on respite

breaks.

The provider had also collected commentary and feedback from family members/resident representatives. Family also spoke positively about the staff team, calling them "simply amazing people" who went "above and beyond" to make sure their loved ones have a good experience. Family were happy that they would be kept updated on any concerns or incidents in the centre, with some feedback indicating where families wanted more detail of what the residents did during their respite breaks. The inspector met a family member who was at the centre during the day, who praised the person in charge for being flexible in accommodating respite breaks at short notice, and was assured that where they had recently made a complaint, there had been no recurrence of the issue.

The inspector observed records of weekly resident meetings in January 2025. In these meetings, residents contributed ideas of what they would like to do in the house and in the community during their break. Some residents were supported to participate in household chores such as doing the recycling or helping staff cook.

The next two sections of the report present 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 the service being delivered.

Capacity and capability

This unannounced inspection was completed due to the length of time since the last regulatory inspection, to monitor and review the arrangements the provider had in place to ensure continued compliance with the Care and Support regulations (2013), and to follow up on information received by the Chief Inspector of Social Services. The inspector found that the centre was staffed by a knowledgeable and experienced front-line team who demonstrated good knowledge of residents' interests, routines, personalities and daily support needs. However systems in place were not effective in demonstrating that management and oversight processes were being followed consistently and in a timely fashion.

This inspection was facilitated by a nurse who supported the person in charge locally, and a person in charge from another designated centre. Later in the day the assistant director of service joined to support the team to locate evidence and access systems to demonstrate regulatory compliance. These personnel had an overall good knowledge of auditing, supervision and risk management systems, and where information was available, they could provide this to the inspector. However, much of the documentary evidence to demonstrate that processes were being followed was not available to them for review on this inspection.

The inspector was not assured that supervision and performance management

meetings between staff and their line manager were effectively establishing and evaluating career development goals and competency assessments. Evidence was not available that staff on probation were in receipt of competency review, including staff who were at the end of the six-month period. Minutes of team meetings were not available for review weeks after they had taken place, for reference by people who were not in attendance.

Annual reports captured achievement and challenges in this designated centre and incorporated learning from engagement with residents availing of respite breaks and their representatives. A number of the findings on this inspection were outstanding actions from when they were identified in the reports of the provider's own six-monthly inspections.

Regulation 15: Staffing

The designated centre had a full complement of staff on the team, with two full-time staff on long-term leave. The inspector was provided worked rosters for January to March 2025 and observed that while 65 shifts had been covered in this time by relief personnel, 48 of these were covered by three regularly attending relief personnel. This mitigated the impact on continuity of staff support during absences of core team staff. Nursing staff absence had been temporarily filled, to ensure that there was a nurse on site at all times as per the statement of purpose. The inspector met with front-line staff on shift during this inspection, including relief staff, and found them to have an overall good knowledge of the residents staying in the centre and their support structures, personal plans, communication, medicines and dietary supports.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the provider's policy on supervision of staff, including how frequently staff would meet as a team and individually with their respective line manager. The inspector requested minutes of these one-to-one supervision meetings for a sample of five members of the front-line staff team selected from the worked roster. The provider could not provide evidence that these staff members had attended supervision meetings in the past six months. For two newer staff members who were in their probationary period, there was no evidence available that they had met with their manager. Overdue supervision meetings was a finding in a December 2024 audit of the service and was also discussed in a February 2025 governance meeting.

The staff were also supervised through team meetings. The most recent minutes

available for review were from November 2024. In these, the team discussed matters including adverse incidents, training required, maintenance issues and updates related to residents and staffing. Staff told the inspector they believed there had been at least one team meeting since then, however could not access minutes of these. The inspector was not assured that staff who had not attended these meetings had timely access to details on discussions they had missed.

The inspector was provided a live training matrix of courses attended by the staff team. Staff had completed training in subjects such as assisted decision making, human rights, and supporting people with epilepsy. Each entry noted the date of completion and when training was due to be refreshed. Using this training matrix, the inspector found gaps in mandatory training for the nine contracted staff in this centre, including five gaps in medicines management training, one person who had not completed Children First training, and two staff who were overdue to refresh their training in fire safety.

Judgment: Not compliant

Regulation 21: Records

During this inspection, records required under the regulations or documentary evidence being used to demonstrate regulatory compliance were not maintained or readily available or retrievable for inspection. Some records contained inaccurate or incomplete information, and in some examples, staff were not aware of where to find information which should be available to residents and families such as the annual report or the statement of purpose. Examples are discussed further in other sections of this report and include staff guidance and review of resident care and supports, evidence that meetings and supervision processes were occurring per policy, complaints, incident reports and investigations.

Judgment: Not compliant

Regulation 23: Governance and management

The inspector was provided reports of six-monthly provider inspections which had taken place in July and December 2024. These reports were detailed and clear on the evidence contributing to actions and areas for development, and included topics such as staff training and supervision, timely access to information, risk assessments, complaints, routine checks and staffing vacancies. The inspector observed the provider highlighting where findings had improved or been repeated between the July and December inspections; the provider scored itself 76% and 91% on adherence to regulatory requirements, standards and provider policy.

The inspector read the annual report for this designated centre, dated November 2024. This review reflected on the achievements and successes of the previous year and what actions and objectives would be set out for the year ahead. This report contained commentary and feedback gathered from residents and their representatives, as well as including pictures of the residents enjoying activities in the centre and going on day trips with their peers and with staff.

As the person in charge was absent on the day, this inspection was facilitated by a nurse leading the shift, a person in charge who arrived from another centre, and an on-call senior manager at provider level, as described in the statement of purpose. These three staff were familiar with procedures and processes related to the centre operation and were able to facilitate the majority of the lines of enquiry on this inspection. However, much of the evidence required to demonstrate compliance with regulations could not be provided through a combination of it not being available to the deputising managers, or a lack of assurance that processes had been followed. The inspector observed gaps in processes and routine tasks including incident reporting, management of risk items, medicine checks on admission, and ensuring that records were complete, up to date, and available for review.

The inspector reviewed the policy on performance management dated December 2023. In this, staff and their manager were required to set out career development goals by February each year, attend two mid-year reviews, and by December these objectives and competency developments would be assessed and evaluated using a meeting template form. The inspector was provided minutes of performance management meetings for three team members and reviewed these with the covering person in charge. The inspector found that these staff members had attended three meetings each between May and September 2024. Minutes from these meetings were found to be generic and lacked detail about staff member's career goals or performance development objectives relative to their role and duties. The majority of these minutes consisted of the same bullet points reminding staff to complete their mandatory training and familiarise themselves with care plans. As none of the sampled staff had attended an end of year meeting in 2024, competency and performance evaluations per the purpose and template provided had not been recorded. Additionally, for two newer staff members who were in their probation period, no evidence was available that they had had their competencies and support objectives evaluated, including one staff member who was at the end of their probation.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had a policy on complaints management dated August 2024 which set out the procedure for receiving, recording and responding to complaints made in or about the designated centre. The inspector was provided a log of complaints for 2024 which contained two entries. For these, the inspector observed clear record of

the details of the complaint, and what action was taken on foot of these. The inspector was advised that another complaint about resident care had been made and concluded to the satisfaction of the complainant, however, this was not collected in the log to ensure that all complaints were available for review or trending; this is captured under Regulation 21 Records. Residents and family/representatives commented in person or in feedback forms that they were satisfied that making complaints would result in action being taken.

Judgment: Compliant

Quality and safety

Overall the inspector observed that residents were happy and their choices and routines respected while they availed of respite service. The inspector found that front-line staff demonstrated good knowledge of residents' supports including communication styles, meal preferences, medicines management and preferred daily routines. Residents were observed to be comfortable and relaxed during their stay, and the inspector observed how this comfort was protected by staff, for example in what needed to be ready on their return to the house from day service.

Some gaps were observed in risk assessment and management procedures, which will be described later in this report. This included evidence that procedures were available to staff, or being followed, regarding hand hygiene, management of medical or fire risk items, investigating injuries, and confirming that restrictive practices were used only as a last resort measure.

Safeguarding of residents from risks related to interactions with their peers was used as a factor when determining how residents would or would not be scheduled to stay together, to maintain a low arousal and relaxed environment during respite breaks. The premises was homely, spacious, comfortable and allowed residents to pursue their own recreation and routines together or alone. Ideas for outings and activities were being discussed in team meetings to ensure all staff consistently delivered quality care and varied and interesting engagements during respite stays.

Regulation 17: Premises

The premises of the designated centre was spacious, clean and in a good state of repair. Each resident had a private single bedroom during their stay and shared use of multiple communal spaces, bathrooms, garden and kitchen. Minor maintenance issues were observed around the house and the inspector observed that these were being reported to a facilities team, and more urgent repair works carried out in a timely fashion after identification.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents were supported to have access to healthy and varied meals, drinks and snacks. Front-line staff demonstrated a good awareness of residents' food preferences including their preferred meal times. The inspector reviewed a sample of care and support plans around food and nutrition and found that this matched what was observed in person and what staff knew about the residents. No residents who attended this centre required texture modifications or supportive systems to eat or drink safely.

Judgment: Compliant

Regulation 26: Risk management procedures

During this inspection, the inspector observed a number of areas in which there were gaps in risk assessment and control measures, staff guidance and incident reporting, and oversight of routine safety features. Some examples of these are described in other sections of this report.

The inspector observed evidence that staff could not refer to guidance on how to manage items of risk, and areas in which such items were not managed appropriately. For example, an oxygen cylinder was stored in the office paperwork cabinet. This had not been identified as a safety hazard in the event of an electrical fire, and there was no signage to denote its storage location. The oxygen cylinder was also not subject to routine checks as identified as an action in a recent audit, and it was past its expiry date for service. A medical waste container was also stored here, and was not closed to prevent risk of needle stick injury. Plastic medical stock such as oral syringes were stored in an open container with no means of controlling risk of cross-contamination and ensuring single-person use. Bathrooms were not equipped with means for staff and residents to wash their hands. The smoking area in the centre's garden was not equipped with fire safety equipment.

The inspector discussed incident reporting with staff and management, and observed a number of gaps in reports recorded. This included a lack of any incident reports for instances in which chemical restraint was required in response to aggression incidents, to be assured of procedure followed and learning for future reference. Where injuries were observed on residents which could not be explained by centre staff, records of other parties contacted to establish cause and rule out safeguarding concern were not available.

Judgment: Not compliant

Regulation 27: Protection against infection

The inspector spoke with staff regarding storage and disposal practices of medical clinical items in the centre. While discussing medicine practices with staff the inspector observed a large number of oral syringes stored in an open plastic container, many of which were not clean or were discoloured. Staff told the inspector these would be used in cases where medicines did not arrive with a syringe, and would be boiled in water between uses. There was no guidance available to confirm this and the inspector was not assured that these syringes would not be shared between different people. When asking how staff sanitised their hands while handling medicines, the inspector was given a bottle of hand sanitiser which was expired by a year. Sharp clinical items such as pen needles and lancets were disposed of in a clinical waste box, however this box was not closed, creating a risk of injury.

The inspector walked the premises after staff had finished their morning tasks, and again later in the afternoon. During these checks the inspector observed that hand sanitiser dispensers around the house were empty, and observed that the three shared-use bathrooms and toilets in the house did not have hand soap or towels available. The inspector was not assured how staff and residents had been facilitated to wash their hands during the day. At the end of this inspection, the inspector was advised that a delivery had arrived to replenish the soap, hand gel and towel dispensers around the house and in the toilets.

Judgment: Not compliant

Regulation 28: Fire precautions

The inspector walked the premises of the centre and observed suitable features to detect, contain and alert staff to fire or smoke in the house. The house had an addressable fire alarm system which included storage and attic spaces. Fire extinguishers, emergency lighting and door closure mechanisms were serviced and checked by an external company regularly.

For each resident, guidance to support evacuation was available to staff. The emergency plan also explained to staff how to respond to a fire, and to where residents and staff could go if unable to return to the house following an evacuation. The house team had practiced evacuation scenarios and the provider was assured that staff and residents could effect a timely egress during the day or night.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The inspector reviewed prescription sheets and administration records with a member of the front-line team, who demonstrated good knowledge of the purpose and instructions for each medicine used by the residents. Where medicines had special instructions or protocols for their use this information was readily available for staff. Regular medicines were available and suitably stored, and a medicines fridge was available for when required.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspector reviewed a sample of behaviour support guidance provided to staff to support residents who responded to distress or anxiety in a manner which presented a risk to themselves or other people. Positive behaviour support plans were person-centred and described the potential types of risk behavior which may present, such as aggression towards others or self-injury. Plans guided staff in strategies to retain a low-stress environment for each person and how to reduce risk of an incident occurring. However, review was required in guidance provided to staff in the event that proactive measures had been ineffective and the resident was engaged in their identified risk behaviour. Response plans referenced tools such as bean bag chairs and protective head wear which were not used in this centre. Staff advised that the guidance they had been provided was relevant to a different care setting and had not been revised since 2017. The inspector discussed this with management, who advised that the provider has had difficulty getting behaviour support plans from other service providers. It is the responsibility of the registered provider to ensure that their staff team are provided guidance to support residents and staff to remain safe.

The inspector reviewed quarterly reports submitted to the Chief Inspector through 2024 outlining the types and frequency of physical, environmental and chemical restraint used in this designated centre. Use of these interventions were only implemented for respite residents with a clearly identified risk, and were not engaged when they were not staying in the centre. As an outcome, this controlled the risk of residents being impacted by restrictive practices which were not relevant to them, such as limiting access to the kitchen.

The registered provider notified the Chief Inspector that chemical restraint had been utilised on eight occasions between two residents in 2024. No incident reports had been completed for these occasions, and there was no evidence available of how the person in charge and provider was overseeing the procedure staff had followed and parties consulted with, to be assured that chemical restraint was only administered in line with protocol and only used when less restrictive de-escalation

strategies had been exhausted.

Judgment: Substantially compliant

Regulation 8: Protection

The provider and person in charge were responsive to risks associated with negative interaction between peers. Concerns and previous incidents which indicated compatibility issues were taken into account when scheduling respite breaks to support residents to spend their time in the centre safe and happy with their peers. Residents indicated to the inspector that they felt safe when they stayed in this centre and were observed to be comfortable with staff and other service users.

The inspector requested staff guidance on protocols to follow when injuries were identified on residents. The inspector was provided the policy on potential indicators of abuse and how these were recorded and investigated. While the staff kept body charts for when bruises or marks were observed on residents on admission, after day service or during their stay, there was no evidence to indicate that when the cause was not known, these injuries were being investigated to rule out potential abuse.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The inspector observed evidence that staff had attended training courses in understanding and protecting the human rights of people with disabilities. The provider had set an action for 2025 that examples of how this training was being implemented by staff in practice would be discussed as a standing agenda item at team meetings. Staff had also completed training in assisted decision making. The inspector observed examples of respectful interactions and friendly rapport between staff and residents, and residents being supported to spend their time alone if that was their preference. Residents were observed to be supported in their choices, and the inspector observed good use of a resident's non-spoken manner of communication being supported and responded to by front-line staff to ensure their choices were understood by staff.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Bower House OSV-0005608

Inspection ID: MON-0046404

Date of inspection: 20/03/2025

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The person in charge and the Assistant Director have completed formal supervision with every member of the staff team in the centre, including those in their probationary period. A schedule is in place for the remainder of the year and progress will continue to be monitored at monthly governance meetings with the Assistant Director of Service. All team meeting minutes have been disseminated to the staff team and made available for review in the centre. There is a schedule of meetings in place for the remainder of the year and this will be continuously reviewed by the Assistant Director of Service to ensure the minutes are present and available to the team. A monthly report will be provided by the Assistant Director of Service to the Director of Service to provide assurances that all mandatory training an refresher training is completed in a timely. The Person in charge has completed a full review of all training required in the centre. All in-person training has been scheduled at the earliest available date. All online training that was outstanding on the day of inspection has now been completed and will continue to be monitored at monthly governance meetings with the Assistant Director of Service	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The Assistant Director of Service has undertaken a full review of all records that were not available on the day of the inspection. These are now all present and available in the centre. This will be continuously monitored during governance meetings and unannounced visits to the centre from the management team. The Person in Charge has provided guidance for the staff team on the purpose and location of various records such as the annual report or the Statement of Purpose.	

Additionally these documents have been made available at the front entrance of the centre for ease of access by staff, residents, and relevant visitors.

The PIC has and will continue to conduct regular audits of all records and documentation to ensure ongoing compliance with Regulation 21. Audits and action plans arising from these audits will be promptly addressed and recorded through monthly governance meetings by the Assistant Director of Service.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

An action plan for service improvement has been developed and implemented. The Person in Charge (PIC) will review the implementation of this action plan through ongoing oversight, monthly governance meetings, and regular audits to ensure continuous compliance. This will also be monitored for progress by the Director of Services on a regular basis.
In line with the policy on performance management the person in charge and the Assistant Director of Servcie have completed formal supervision with every member of the staff team including those in their probationary period. A schedule is in place for the remainder of the year and progress will continue to be monitored at monthly governance meetings with the Assistant Director of Service.
The Assistant Director of Service will retain oversight of staff supervisions on a monthly basis to ensure they are tailored to the individual and not generic in content. The Director of Service will retain oversight of all monthly governance meetings and review action plans arising from same. In addition the Director of Service will conduct a weekly visit to the centre until such time they are assured that all matters arising from this report have been satisfactorily addrressed.

Regulation 26: Risk management procedures	Not Compliant

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

The oxygen cylinder, which is no longer required within the centre, has been removed. The sharps disposal box has been replaced, and arrangements have been made for maintenance staff to secure to the wall. Clear, adequate safety signage has been displayed around the sharps box, providing essential safety instructions and information for staff. Staff training has been completed regarding the safe disposal of sharps. Daily checks are conducted by nursing staff to ensure that the centre is in compliance with the IPC policy and the correct disposal of single use syringes is in effect.

The Person in Charge has developed a daily checklist to ensure that all handwashing facilities are fully stocked. This is now included on the daily handover for the staff team and is reviewed weekly by the Person In Charge.

The staff team have been requested to refresh their training in specific AMRIC online modules. An on-site IPC training session is scheduled for the staff team with the Nurse Practice Development Coordinator. IPC champions have been identified within the centre to ensure best practice standards are maintained.

Fire safety equipment has been added to the smoking area in the centres garden.
The Assistant Director of Service and the Person in Charge have completed a full review of all incidents of chemical restraint and advised the staff team to record incidents in line with the Incident Management Policy and the PRN medication policy and this will be monitored by the Assistant Director of Service.

The Providers policy on Adult Protection is undergoing revision to provide staff with clarity and additional guidance in the management of unexplained injuries

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:

Daily checks are conducted by nursing staff to ensure that the centre is in compliance with the IPC policy and the correct disposal of single use syringes is in effect. All cleaning schedules have been revised and are monitored daily by the Person in Charge.
The Person in Charge has provided instruction to staff members on the correct procedures for ordering cleaning and infection prevention and control equipment. This will ensure timely availability and accessibility of required IPC resources.

The Person in Charge has developed a daily checklist to ensure that all handwashing facilities are fully stocked and is reviewed weekly by the Person in Charge.

The staff team have been requested to refresh their training in specific AMRIC online modules.

An on-site IPC session is scheduled for the staff team with the Nurse Practice Development Coordinator. IPC champions have been identified within the centre to ensure best practice standards are maintained.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

All residents presenting with behaviours that challenge specific need care plans are under review by the Person in Charge to ensure they clearly outline both proactive and reactive strategies for safely and effectively supporting the resident. These plans will be developed using supporting evidence from Positive Behaviour Support Plans (PBSPs) from other services, relevant assessments, input from family members, and staff experience within the centre.

The Assistant Director of Service and the Person in Charge have completed a full review of all incidents of chemical restraint and advised the staff team to record incidents in line with the Incident Management Policy and the PRN medication policy and this will be monitored by the Assistant Director of Service.

The Chief Operating Officer has completed a Lunch & Learn guidance session on restrictive practice guidance on the 29th of April 2025.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

The Providers policy on Adult Protection is undergoing revision to provide staff with clarity and additional guidance in the management of unexplained injuries.
The Person in Charge has ensured that skin integrity charts for if bruises or marks are observed on residents on admission, after day service or during their stay are continuing to be maintained.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/05/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/05/2025
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.	Not Compliant	Orange	15/06/2025
Regulation 21(1)(c)	The registered provider shall ensure that the additional records	Not Compliant	Orange	15/06/2025

	specified in Schedule 4 are maintained and are available for inspection by the chief inspector.			
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	15/06/2025
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	15/06/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of	Not Compliant	Orange	30/05/2025

	risk, including a system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	30/05/2025
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	15/06/2025
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive	Substantially Compliant	Yellow	15/06/2025

	procedure is used.			
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Substantially Compliant	Yellow	15/06/2025
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	30/05/2025