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:	Announced
Date of inspection:	17 June 2025
Centre ID:	OSV-0008307
Fieldwork ID:	MON-0038521

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 is located on the provider's campus setting in Islandbridge. Liffey 8 provides full-time residential care and support to residents with a moderate to profound intellectual disability and additional support needs in the areas of behaviours of concern, sensory needs, communication and specific dietary requirements. Residents are provided with their own bedroom, a living room and a kitchen as well as a small courtyard, and they are supported to access facilities in the community and those available on the provider's campus. Residents have access to multidisciplinary professionals through the provider's own clinical team as well as community allied health care professionals. The centre is staffed by a team of social care workers and a staff nurse 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
Tuesday 17 June 2025	12:15hrs to 20:00hrs	Jennifer Deasy	Lead

What residents told us and what inspectors observed

This was an announced inspection carried out in response to the provider's application to renew the centre's registration. The inspection took place over the course of an afternoon and evening and the inspector had the opportunity to meet all three residents living in the centre and two resident family members. The inspector used conversations with staff and family members, observations of care and support and a review of documentation to inform judgments on the quality and safety of care.

Overall, residents were in receipt of good quality care which was enabling them to have enhanced opportunities for social inclusion and engagement; however, there were areas for improvement identified on this inspection in relation to staff training and supervision and resident care plans. These deficit areas have previously been identified on inspections of this centre. There had been multiple changes to the management systems of the centre within the past three years which contributed to these deficits arising. This will be discussed further in the capacity and capability section of the report.

The designated centre is comprised of two buildings located on the provider's campus in Dublin. The larger of the properties is home to two residents, and the smaller of the properties provides accommodation to one resident. Prior to this centre being registered in 2022, these three residents had lived in a much larger, congregated setting on campus. The aim of moving residents to this designated centre was to provide more individualised care with a focus on community participation.

The inspector first met the resident who lived in the single occupancy premises. They appeared to be very comfortable and relaxed in their home. They greeted the inspector, shook her hand and invited her in. The resident was observed to be listening to music in their sitting room and looking at a book. The staff on duty told the inspector that the resident had been out for a walk and that they were going to have their lunch shortly. The resident asked the staff for tea and the inspector saw that the staff member responded promptly and assisted the resident to get their tea. The resident then asked for their dinner and staff responded kindly and prepared the meal.

The resident presented with an assessed dietary support need. The inspector was told that their food was therefore prepared by a chef who was based in a neighbouring designated centre. The chef had received specific training in respect of this assessed need and prepared food that was in line with the resident’s care plans. The meal was nicely presented and looked and smelled appetising. The staff on duty told the inspector that they had also received training specific to the resident's dietary needs and showed the inspector how they recorded the food provided to the resident and the specific nutritional qualities of the food. The staff also demonstrated to the inspector that there was availability of specific foods in the

centre that were suitable to meet this resident's dietary requirements. This allowed staff to prepare suitable alternative meals if the resident declined the meal prepared by the chef or if they wanted a snack during the day.

The inspector observed the resident's home was very clean and well-maintained. They had access to their own kitchen, bathroom, bedroom and sitting room. There was some upkeep required to the courtyard at the back of the house; for example, a Perspex roof required cleaning and there was no outdoor furniture or plants for example. The inspector was told that the provider had plans to enhance this outdoor space in the future.

In the resident's home, the inspector observed photographs of the resident engaging in different activities on display in the kitchen. The staff on duty told the inspector that they had recently gone on a holiday for two nights and that this had been a great success. They were supporting the resident to plan another holiday at the time of inspection. The inspector was also told that the resident enjoyed a range of activities including music therapy, massage and walks in the community. The staff on duty spoke of the positive relationship that the resident had with their family and of how they regularly visited them and spent time with them. Overall, the inspector saw that the resident appeared happy and relaxed, that they were living in a clean and safe home and that the staff on duty knew their needs and preferences well.

The inspector met the other two residents who lived in the larger property in the afternoon. The two residents had been at their day service and were supported to relax in their sitting room with a drink on their return. It was a hot day and the inspector was told that both residents had been busy and active at day service. The inspector saw that there were enough staff on duty to support both residents to maintain their hydration in line with their needs.

The residents appeared comfortable and relaxed, and positive and friendly interactions were heard between the staff and the residents. Both of these residents communicated through non-verbal means. While the inspector saw that staff consulted with the residents throughout the afternoon and communicated with them regarding their routine, it was not seen that this communication was in a format suitable to meet the residents' communication needs. Staff told the inspector that they endeavoured to provide information to residents about their rights but they had not received training in how to adapt their communication to meet residents' assessed needs. This is discussed further in the quality and safety section of the report.

A dinner time meal observation was completed. The inspector saw that food was provided which was nutritious and looked and smelled appetising. Food and drinks were modified and prepared in line with residents' assessed feeding, eating, drinking and swallowing (FEDS) care plans. Residents had access to prescribed equipment to enable their autonomy in respect of mealtimes. There were also sufficient staff on duty to assist residents if required and the inspector saw that this assistance was provided in a manner that promoted the dignity of the residents.

Later in the evening, one of the residents was supported to relax in their bedroom and look at sensory lights and listen to music. The other resident was supported to have a shower. They were seen to be smiling and engaging with staff. Positive and kind interactions were observed and the care provided for showering upheld the resident's privacy and dignity.

This house was seen to be large, comfortable and homely. Residents each had their own bedrooms which were personalised. They had access to an accessible bathroom, two sitting rooms, a kitchen and a utility room. Upkeep was also required to the back garden of this centre, with the staff stating that the provider's maintenance team were aware that this was required.

The inspector had the opportunity to meet and speak with the family members of two of the residents who lived in the designated centre. The feedback from family members was mixed. One family member expressed that, while they were overall satisfied that there had been improvements made to the centre, they had concerns regarding some aspects of the premises and the provider's capacity to complete actions in a prompt manner. For example, they spoke of works required to the courtyard and expressed frustration that these works had not yet been completed. They also expressed dissatisfaction with the provider's consultation with them regarding changes made to the premises and the resident's care needs. They told the inspector that they had made complaints in respect of their concerns, although they were generally not satisfied with the response by the provider.

A second family member spoke positively of the service. They told the inspector that they were very happy that their loved one had transitioned into Liffey 8 from the larger centre that they had previously lived in. They stated that the resident was in receipt of more individualised support and that they were more relaxed and content. They felt that the resident got on well with their housemate and that they were compatible. They spoke fondly of a family gathering that they had in the centre at Christmas and described how another family member had commented on just how well their loved one appeared. The family member said that the centre was very homely and that there was "a lovely energy in the building". They said that they had no concerns in respect of the service but they were aware of who to contact if they did have concerns, and felt that the management and staff team were very responsive to them.

The inspector also reviewed two residents' questionnaires. One of these had been completed by a family member and the other by a staff member, on behalf of the residents. Both questionnaires detailed that the centre was a nice place to live, that the staff were kind and the residents were happy with the facilities. One questionnaire indicated that the resident would like enhanced opportunities to go on trips and visits.

Overall, the inspector saw that residents were living in clean, homely and well-maintained houses. Residents were seen to be comfortable and relaxed in their homes. They were well dressed and were seen smiling and relaxed in the company of staff. Kind and respectful interactions were observed between staff and residents.

Staff responded promptly to residents' communications and ensured their needs were met in a timely manner.

The next two sections of the report will describe the governance and management arrangements and how effective these were in ensuring the quality and safety of care.

Capacity and capability

This section of the report describes the oversight arrangements for the centre. The inspection found that multiple changes to the management arrangements in the most recent registration cycle had resulted in gaps in oversight and some regulatory drift in compliance. In particular, there were gaps in the local oversight arrangements which meant that staff were not consistently performance-managed to ensure they had the knowledge and training to fulfill their professional responsibilities.

The designated centre, at the time of inspection, had competent managers with appropriate qualifications. There was a defined management system and staff and family members spoken with were aware of how to escalate concerns through these systems. However, multiple changes to the management systems and, in particular, to the person in charge role had resulted in a lack of oversight of the day to day provision of care. The impact of this was that, although residents were seen to be happy and comfortable in their home, there was a lack of sustained effort to drive service improvement for the residents; for example, by ensuring that residents had access to information in a format suitable to meet their communication needs.

The changes to the local oversight arrangements also meant that staff were not consistently supervised and performance-managed to ensure that they had the required competencies to manage and deliver safe services to the residents. Many of the staff were overdue refresher training in key areas, and some of the residents' care plans did not provide sufficient guidance to staff in respect of residents' support needs. The inspector observed one practice in medication administration that required improvement. There was a lack of guidance on the medication care plan around this need and three of the staff were overdue training in medication administration. This is discussed in more detail under regulation 29.

Staffing vacancies continued to impact on the overall continuity of care for the residents, in particular for one of the houses that comprised the centre. The management team had implemented contingency plans however it was not evident that these were wholly effective in ensuring continuity of staffing so that positive attachments could be maintained. On review of the actual rosters for one of the houses, at times, nursing shifts were filled by other staff such as social care workers or healthcare assistants. Therefore, the required level of nursing resources were not always implemented as prescribed by the centre's statement of purpose, although it

was not evident that this resulted in a medium or high risk to residents as residents were not assessed as requiring continuous nursing care.

The new management team had self-identified some of the deficits identified by the inspector, for example, the staff training needs. They were endeavouring to address this issue and had booked staff in for refresher training in the coming weeks and had schedules to provide supervision to staff in 2025. The provider had procedures in place to audit the quality and safety of care and these had identified some of the risks, for example in respect of the communication needs of residents. Action plans had been implemented; however, there was a failure to progress some required actions in a timely manner.

The designated centre had a statement of purpose and a residents' guide available in the centre which defined the services and facilities available in the centre. Information on the complaints procedure was available and the inspector saw that complaints were recorded and were responded to promptly.

Overall, while there were defined management systems at the time of inspection, multiple changes to key stakeholder roles during this registration cycle had resulted in reduced local oversight and posed some risks to the quality and safety of care.

Registration Regulation 5: Application for registration or renewal of registration

A full and complete application to renew the centre's certificate of registration was submitted. The fee was paid and prescribed information was also submitted. This afforded the centre the protections of Section 48 of The Health Act (2007) as amended while going through the renewal process.

Judgment: Compliant

Regulation 14: Persons in charge

A full-time person in charge had recently been appointed to oversee the designated centre. They were suitably qualified and experienced and demonstrated that they understood the residents' needs. They had access to management hours to fulfill their regulatory responsibilities and were supported in their role by a clinical nurse manager 2 and a programme manager.

Judgment: Compliant

Regulation 15: Staffing

There were mixed findings in respect of the staffing allocations of the designated centre. In the smaller house, it was seen that the resident was generally supported by four consistent staff members who had worked with the resident for some time and were well informed of their needs. A staff member spoken with demonstrated a comprehensive understanding of the resident's needs. They described how consistency of staffing was key for the resident, and that due to the consistent staff arrangements, there had been a reduction in incidents of concern in the centre. The staff member told the inspector that there were some relief or agency staff required on occasion; however, there were systems in place to ensure that familiar agency and relief staff were used and that they received an induction from management before commencing their shift.

There were two staff vacancies in the larger of the houses. One of these vacancies had only occurred at the end of April 2025 while the other had been vacant for a longer period. The inspector was told that the provider was endeavouring to recruit new staff for the vacant roles.

The inspector reviewed the rosters for this house and saw that the provider was endeavouring to use consistent relief and agency staff in order to fill the gaps in the roster arising from vacant posts; for example, in a period of six weeks from April to June 2025, 17 shifts were required to be filled. These were filled by seven agency staff, with two of these agency staff completing the majority of shifts.

The inspector was told that relief and agency staff were rostered on with familiar staff as much as possible to reduce the impact on residents; however, there were times when there were only relief or agency staff available to the residents. For example, on 31 March 2025, the two day shifts were filled by agency staff and on 10 April 2025, both day shifts were filled by a relief and an agency staff. The inspector was therefore not wholly assured that the arrangements to manage gaps in the roster posed by vacancies were effective in ensuring continuity of care.

The planned and actual rosters for the larger of the houses were reviewed in detail. Residents in this house were assessed as requiring nursing supports and one whole time equivalent nurse had been allocated to the staff team. The inspector saw, on four occasions in March and April 2025, that when the staff nurse was unavailable due to planned leave, these shifts were completed by staff who were not nurses, such as health care assistants and social care workers. It was not evident that residents were in receipt of nursing supports at the level as detailed on the statement of purpose. However, this did not appear to be resulting in a medium to high risk to residents as they were not assessed as requiring continuous nursing inputs. It was also noted by the inspector that both family members spoken with were familiar with the staff team and spoke positively of the care and support that they provided.

The inspector reviewed the Schedule 2 files for three of the staff who were working in the centre. It was seen that all of the required documentation was maintained including, for example, an up-to-date and valid Garda Siochana vetting disclosure.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Due to multiple changes to the oversight arrangements, the staff team had not received consistent supervision from management. One staff member reported that they had not received formal supervision in over a year, and when the inspector reviewed the supervision records for this staff, she saw that the last documented formal supervision session was in August 2023.

The inspector was told that staff meetings should have been held monthly, however, there were only three documented staff meetings for 2024 for both of the staff teams in the designated centre.

Without documented consistent staff meetings and staff supervisions, it was not evidenced that staff were adequately supervised in respect of their work and their defined responsibilities.

The staff training records reviewed by the inspector showed that several staff required updated training in key areas. For example, all eight staff were overdue practical hand hygiene training; three staff were overdue safe administration of medications training; and seven staff were overdue infection prevention and control training.

One staff was seen to be long overdue refresher safeguarding training. It was documented that this was last completed in 2018. One staff was also very overdue crisis prevention intervention (CPI) training, having last completed this in 2021. The staff training records showed refresher training should be completed in both these areas every two years. This posed a risk that staff did not have the most up-to-date training to guide them in adhering to best practice in the provision of care and support.

Judgment: Not compliant

Regulation 22: Insurance

The provider submitted copies of their certificates of insurance as part of the application to renew the centre's certificate of registration. The inspector saw that the provider had effected a policy of insurance against injury to the residents and against damage to the property.

Judgment: Compliant

Regulation 23: Governance and management

At the time of inspection, there were clearly defined management systems. The staff team reported to a person in charge. They were supported in their role by a clinical nurse manager and a programme manager. These stakeholders had all been appointed to their positions within approximately the last 12 months which meant that there had been a number of changes to the oversight arrangements since the centre was registered.

There had been multiple changes to the person in charge role, in particular, with four different persons in charge having responsibility for the centre at different times within this regulatory cycle. These changes had resulted in gaps in oversight especially at local level. For example, staff were not performance managed through regular staff meetings and staff supervisions. It was not evidenced that there was regular oversight to ensure that the day to day delivery of care was in line with best practice and adhering to the provider's policies. Examples of the impact of the reduced oversight on staff practices are further detailed under regulation 10 and regulation 29.

The inspector saw that, since their appointment, the new management team had made efforts to ensure that staff were in receipt of regular support and supervision. Three staff meetings had taken place since January 2025 and some staff had received a one to one supervision meeting. The person in charge had in place a schedule of supervisions to ensure that all staff received supervision in 2025 that was as frequent as defined by the provider's policy. Two staff members spoken with told the inspector that the management team were responsive and readily available to them.

The changes to the oversight arrangements had also resulted in a failure to progress some actions as identified on the provider level audits in order to ensure the quality of care. For example, the provider's six monthly unannounced visit in October 2024 identified that the communication section of a resident's individual assessment required updating, however this had not been completed at the time of inspection.

The provider had completed an annual review of the quality and safety of care of the service in 2024; however, it was not evident that residents and their representatives were consulted in respect of this review and that their views were used to inform an action plan arising from it.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

A statement of purpose was available in the designated centre. This was reviewed by the inspector. It was found to contain all of the information as required by the

regulations; for example, there was information on the staffing allocations and the services and facilities provided.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had in place a complaints policy and procedure which was displayed in the designated centre. Two family members spoken with were informed of the complaints procedure and of how to make a complaint.

One family member told the inspector that they had made a written complaint recently regarding aspects of the premises of the centre and the care and support being provided to the resident. The inspector reviewed the complaints records and saw that the family member's complaint had been acknowledged in writing by the provider within a prompt timeframe. The complaint remained open at the time of inspection.

Judgment: Compliant

Quality and safety

This section of the report describes the quality of the service and how safe it was for the residents who lived there. The inspector saw some examples of very good quality care being provided to the residents; for example in respect of their food and nutrition and the arrangements to support residents to maintain good quality relationships with their family members. However, there were a number of areas for improvement, in particular in respect of residents' communication needs.

The designated centre was homely, accessible and promoted the dignity and privacy of each resident. Bedrooms were decorated in accordance with residents' preferences and there were sufficient bathrooms adapted to meet residents' assessed needs. There were clean and suitable dining and laundry facilities and overall, the centre was clean and warm. The outdoor spaces of both properties required upkeep to make them more accessible and inviting. The staff and programme manager told the inspector that they were aware of this and that there was a plan to improve the outdoor areas.

Each resident had a personal plan which detailed their needs; however, improvements were required to some aspects of these plans to ensure they were informed by a relevant multidisciplinary professional and clearly outlined the supports required to maximise their personal development and quality of life. In particular, enhancements were required to residents' communication support plans.

It was not evident that residents had access to information provided in a format suitable to meet their communication needs to enable them to exercise choice and control in their daily life. A review of resident's medication care plans were also required to ensure that there was specific guidance for staff in the administration of crushed medications.

Residents' plans in respect of their food and nutrition were comprehensive and were informed by relevant healthcare professionals. Staff were informed of these and had received the required training in order to provide appropriate support. The inspector saw that there were sufficient staff to support residents' with their food and nutrition needs in a person-centred and dignified manner.

Residents were supported to maintain their personal relationships with their families and loved ones. Family members were welcomed visitors to the centre and there was private space available for residents to spend time with their families.

Regulation 10: Communication

The residents in this centre presented with communication needs, with two of the residents mainly communicating through non-verbal means such as gestures and facial expressions. The residents' individual assessments detailed that they each presented with communication support needs and that these could impact on their behaviour and wellbeing. For example, one resident was described as having limited verbal communication and that they had behaviours that challenge relating to their communication needs. Another resident's individual assessment described how they had a severe communication difficulty.

The residents' individual assessment of their communication needs had not been informed by a relevant multidisciplinary professional. It had not been established what their specific communication needs were and how staff could best support them to communicate. Care plans had not been implemented in respect of residents' communication needs and there was conflicting information on their files about how best to support them. For example, one resident's "information about me" indicated that they used Lamh sign system but staff were unsure if this was accurate and had not received training in this system.

The inspector saw that there was some visual information in the centre to support residents' communication; for example, a visual staff rota and a menu planner. However, it was not clear how residents were supported to engage with these systems, or if they were suitable to support their communication needs as a comprehensive communication assessment had not been completed. Staff told the inspector that they endeavoured to provide information to residents at residents' meetings regarding important issues such as the the provider's complaints policy or safeguarding. They acknowledged though that much of this information was provided in a written format which was not suitable to meet the residents' literacy needs.

Judgment: Not compliant

Regulation 11: Visits

There was an open door policy for visitors in the centre, as had been detailed in the centre's statement of purpose. The inspector saw that the residents had sufficient private space to meet with their families and loved ones. The inspector met with two family members who visited the centre on the day. One family member described how they had attended a tea party in the centre in December 2024 with their extended family, and how much they had enjoyed this.

Judgment: Compliant

Regulation 17: Premises

The designated centre was designed and laid out to meet the needs and the number of residents. The interior of both properties was clean, homely and well-maintained. Each of the residents had their own bedroom which was personalised to match their tastes. Their bedrooms were also equipped with aids and appliances to meet their needs. Residents had a sitting room, accessible bathroom, kitchen and laundry facilities.

There were improvements required to the garden facilities of both centres in order to make them more welcoming. Weeding of the patio and cleaning of a perspex roof of one of the gardens was required. One of the gardens also required garden furniture and other features to make it more inviting.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

All of the residents who lived in this centre presented with assessed dietary and nutritional needs. The inspector saw that these were detailed on their individual assessment and that there were comprehensive care plans to guide staff in respect of these needs. These care plans were informed by relevant multidisciplinary professionals including speech and language therapists and nurses.

Staff members had received training in respect of residents' food and nutrition needs. One staff member described the measures in place to ensure a residents' care plan was adhered to. These measures included having food prepared by a chef

with specific training, carefully recording the nutritional quality of the food and ensuring that dietary-specific foods were available in the centre.

Other residents required support with feeding, including direct assistance and the use of specific aids to enable increased autonomy in feeding. The inspector observed these residents being supported to take a drink on return from day service and also observed a dinner time experience in the centre. It was seen that residents had access to the required aids to enhance their autonomy in feeding. A family member spoken with described how this had been a significant goal for their loved one and how happy they were that they could feed themselves.

There were sufficient staff on duty to provide support to residents at mealtimes in a person-centred manner. Care was taken to uphold residents' dignity, including for example, by protecting residents' clothes during meals.

The inspector saw meals being prepared in each of the houses. These meals looked and smelled appetising. The staff in one of the houses had access to the required equipment to modify food in line with a residents' assessed needs.

Judgment: Compliant

Regulation 20: Information for residents

A residents' guide was available in the centre. This provided information to residents on the complaints procedure, the process for accessing Health Information and Quality Authority (HIQA) reports, the services provided and the fees for those services.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Medications were stored securely and hygienically in the centre. The inspector reviewed the medication records for two residents and saw that their medications were administered at the time prescribed. Medications were seen to be in date and clearly labelled for the resident for whom they were prescribed for.

There was a risk identified on the day of inspection in respect of the administration of crushed medications. The inspector saw that the crushed medication was added to a cup of thickened fluid and then scooped out with a spoon. This posed a risk that the resident may not receive the full dosage of medication prescribed due to to it adhering to the sides of the cup or being diluted by the volume of liquid. The clinical nurse manager 2, in discussion with the inspector, agreed that this was not in line with best practice. The inspector reviewed the resident's medication

administration plan and saw that there was a lack of guidance for staff on how residents should be supported to take crushed medications. A medication audit completed in May 2025 at local level was found to be ineffective in identifying required actions. For example, the audit detailed that all staff had safe administration of medications (SAMS) training; however, a review of the training records showed that three staff were out of date with this training.
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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Not compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant

Compliance Plan for Liffey 8 OSV-0008307

Inspection ID: MON-0038521

Date of inspection: 17/06/2025

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Vacancies in the DC have active adverts and the recruitment process is in progress. Time Frame: 30.10.2025 • Supervision: Staff will be supervised in line with the SJoG HR policy on supervision. All staff will have 2 supervision sessions unless otherwise required by the end of 2025. Agency/relief staff will be supervised by the line manager as required. The first round of supervision has commenced and will be completed by 30.07.2025 and records will be maintained. • Staff meetings will take place monthly, and records maintained. Time Frame: Completed and scheduled for the remainder of the year. • Rosters: Rosters will accurately reflect the staff members on duty and all staff cover will be guided by the grade that requires cover. The staff rostered are in line with the residents' needs. Time Frame: Completed.	
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 training log has been updated with mandatory and desirable training, training is colour coded for planning purposes. All training out of date has been scheduled. Training will be discussed at each staff supervision. All mandatory training will be completed by the end of September and desirable training will be scheduled as required. Time Frame: 30.09.2025 • All safeguarding training is in date for the frontline staff and records are maintained in the training log.	

• Supervision: Staff will be supervised in line with the SJoG HR policy on supervision. All staff will have 2 supervision sessions unless otherwise required by the end of 2025. Agency/relief staff will be supervised by the line manager as required. The first round of supervision has commenced and will be completed by 30.07.2025 and records will be maintained.
• Staff meetings will take place monthly, and records maintained. Time Frame: Completed and scheduled for the remainder of the year.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The DC will continue to have a monthly DC meeting and Quality and Safety Meeting with senior management team using an updated template for continued Governance and oversight. Time Frame: Complete.
• The training log has been updated with mandatory and desirable training, training is colour coded for planning purposes. All training out of date has been scheduled. Training will be discussed at each staff supervision. All mandatory training will be completed by the end of September and desirable training will be scheduled as required. Time Frame: 30.09.2025
• Vacancies in the DC have active adverts and the recruitment process is in progress. Time Frame: 30/10/2025
• Supervision: Staff will be supervised in line with the SJoG HR policy on supervision. All staff will have 2 supervision sessions unless otherwise required by the end of 2025. Agency/relief staff will be supervised by the line manager as required. The first round of supervision has commenced and will be completed by 30.07.2025 and records will be maintained.
• Agency and relief staff will have an induction to the DC. Time Frame: Completed
• Staff meetings will take place monthly, and records maintained. Time Frame: completed and scheduled for the remainder of the year.
• Rosters: Rosters will accurately reflect the staff members on duty and all staff cover will be guided by the grade that requires cover. The staff rostered are in line with the residents' needs. Time Frame: Completed.
• Unannounced Visits by the register provider: All actions from the unannounced visits will be recorded and actioned accordingly on the Quality Enhanced Plan. A review of the most recent unannounced visit has been completed and actions added with an appropriate timeframe. Time Frame: 16.07.2025
• Residents Personal Plans: All the plans will be reviewed to ensure that all care plans are reflective of their needs. Time Frame: 30.07.2025
• Annual Review 2024 will be reviewed to include feedback from the residents and their representatives' views and any actions identified will be noted and added to the QEP. Time Frame 30.07.2025.

Regulation 10: Communication	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• A comprehensive review of the residents' communication needs, including a referral to relevant professionals, establishing the residents' specific communications needs and all support identified will be implemented. The PIC will ensure this is communicated to the team. Timeframe: 30.08.2025
• Training: All staff will attend training om 'Supporting Communication' as provided by the Speech and Language Dept. Timeframe: 18.09.2025
• Easy Read/Accessible Format Communication: The DC has an easy read and accessible information folder for communicating with the residents, this will be used at the residents meetings and for support communication with the residents. Time Frame: Completed

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The cleaning of the Perspex roof had been added to the on-line maintenance system for completion. Time Frame: 31.07.2025
• Gardening: All gardening upkeep has been logged with the gardening company responsible for the upkeep, the gardening is completed as per the agreed contract schedule. Time Frame: Completed
• Garden Space: A circle of support meetings will be arranged with the resident and their family, to plan the new garden space. The garden will be updated in line with the residents' preferences and needs. Time Frame: 30.09.2025

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• Training: All staff who require Safe Administration of Medication will have it scheduled prior to it going out of date. 3 staff have been scheduled to complete the Safe Administration of Medication and 1 of the 3 have completed the required training. The other 2 staff have been scheduled to attend. Time Frame: 08.09.2025

• A comprehensive medication audit was completed on the 27.06.2025 and all actions have been added to the QEP. This audit will be completed every 3 month by CNM3 to ensure Governance of medication management.
• On the 8th of July 2025, all residents' medication administration plans were updated in line with their needs. Time Frame: Completed

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Not Compliant	Orange	30/08/2025
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Not Compliant	Orange	30/08/2025
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	Substantially Compliant	Yellow	30/10/2025

	statement of purpose and the size and layout of the designated centre.			
Regulation 15(2)	The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided.	Substantially Compliant	Yellow	09/07/2025
Regulation 15(3)	The registered 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.	Substantially Compliant	Yellow	30/10/2025
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.	Not Compliant	Orange	30/09/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/07/2025
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	30/09/2025

	are of sound construction and kept in a good state of repair externally and internally.			
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.	Substantially Compliant	Yellow	27/06/2026
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	30/07/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided	Substantially Compliant	Yellow	16/09/2025

	in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
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.	Substantially Compliant	Yellow	30/07/2025
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, 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.	Substantially Compliant	Yellow	08/09/2025