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:	Ballyseedy House
Name of provider:	Resilience Healthcare Limited
Address of centre:	Kerry
Type of inspection:	Announced
Date of inspection:	04 August 2022
Centre ID:	OSV-0007763
Fieldwork ID:	MON-0028682

About the designated centre

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

Ballyseedy House is a large purpose built detached two-storey house located in a rural area, but within a short driving distance to a nearby town. The centre can provide residential/shared care accommodation for a maximum of six residents of both genders, between the ages of 18 and 65. The centre supports residents with Autism spectrum disorders, intellectual disabilities, physical needs and sensory needs. Support to residents is provided by the person in charge, a team leader and support staff. Each resident has their own en suite bedroom and other facilities in the centre include bathrooms, living rooms, dining rooms, kitchens, a laundry and a staff office.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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 4 August 2022	09:35hrs to 19:15hrs	Conor Dennehy	Lead
Thursday 4 August 2022	09:35hrs to 19:15hrs	Deirdre Duggan	Support

What residents told us and what inspectors observed

The premises provided for residents was seen to be presented in a homelike manner while staff members on duty were seen to engage with residents in a jovial, pleasant and warm manner. Family members of residents gave positive feedback on the services provided. However, there were incidents occurring in the centre which could result in some residents being removed from an area of the centre.

On arrival to this centre it was observed by the inspectors that the exterior of the premises provided was nicely presented and maintained. For example, there were hanging baskets with some plans in them while some tyres had been painted and placed around some trees just outside the premises. The inside of the premises was generally seen to be clean, well-furnished and homelike with numerous framed photographs of residents on display while a "though for the day" sign was also present in one of the centre's halls. It was seen though that some areas of the interior required painting such as around some door frames. Inspectors were informed that painting was due to take place soon.

Each resident had their own individual en suite bedroom. Two of these bedrooms were seen by an inspector and were noted to spacious and well maintained with facilities provided for residents to store their personal belonging such as wardrobes. Six residents lived in this centre all of whom were met by inspectors. While some residents did greet inspectors, others did not engage with inspectors with most residents not communicating verbally. As such inspectors primarily related on observations of residents and their interactions with the staff members on duty during the course of this inspection.

Inspectors were informed that five of the residents received their day services from the centre with the sixth resident attending day services away from the centre which they did on the day of inspection. Of the other residents that remained in the centre it was noted that some walked to a restaurant in the local area, some went for a drives and some were seen to be doing puzzles. Some residents appeared happy at times during this inspection. For example, a resident was seen smiling as they watched some television while another also smiled as they were supported to listen to music in a courtyard area just outside the centre.

It was indicated to inspectors that residents were supported to participate in activities such as attending a gym, doing work in a charity, going to swimming pool and going for walks on a beach. It was noted though, when reviewing residents' activities records, that there were times when the range of activities which residents were recorded as participating in was narrow and repetitive. For example, for one resident it was seen how the only activities the resident were indicated as participating in during a five day period were drives and music. Inspectors were informed that some residents had particular needs in this area and that it could be difficult to encourage some residents to participate in activities.

During this inspection, inspectors observed and overheard staff members engaging with residents in a pleasant and warm manner throughout. At one point a staff member talked with a resident about what costume the resident would wear during Halloween while later the same resident was seen to be supported to attend the staff office to use a printer there. The person in charge was also seen to interact jovially with residents throughout. During this inspection, a family member of one resident spoke with an inspector via telephone and talked very positively of the staff and management in the centre as well as the overall supports that were provided for the resident in question. They also outlined how they were kept informed about their relative on a daily basis.

As this was an announced Health Information and Quality Authority (HIQA) inspection, in advance of this inspection pre-inspection questionnaires that had been issued to this centre to get more information on residents' and/or their families' views of the services provided in the centre. One resident had started one such questionnaire with the support of staff but had not completed it. A family member of one resident had completed a questionnaire and had returned it directly to HIQA. It was noted that this family member gave positive feedback on all areas covered such as care and supports, general happiness, staffing and residents' rights.

While the atmosphere encountered by inspectors on the day of the inspection was generally calm and sociable, during the introduction meeting of the inspection, inspectors were advised that they may hear the vocalisations of one resident and that in 2022 there had been an increase in this resident displaying challenging behaviour. In response to some of these incidents it was indicated that other residents would be "evacuated" from part of the centre. While inspectors did heard the vocalisations of some residents at some points during the day, there did not appear to have been any occasions of other residents being evacuated while inspectors were present.

However, when reviewing incident records and other documents in the centre it was indicated that there had been occasions in recent months where one residents were removed from a communal area of the centre due to the behaviour other residents. Such behaviour including occasions where a resident was "roaring" or banging on windows and doors with some of these incidents indicated as lasting for 45 minutes. Aside from references in some incidents reports to other residents being removed, the incident reports reviewed by an inspector did not indicate if other residents were present during such instances or if they were impacted.

Varying information was provided by staff as to how other residents were impacted by such incidents aside from them being removed from an area of the centre. For example, one staff member said other residents were not impacted while another staff member indicated that some residents would be frightened by the shouting of a resident and that in response one resident would go to their bedroom as this was their "safe place". A third staff member told inspectors that they were unsure how other residents were impacted by these incidents as most residents in the centre could not verbally indicate to staff if or how these incidents affected them.

In summary, some residents were being removed or evacuated from parts of the

centre in response to certain incidents. Residents were observed and overheard to be treated in a positive and warm manner during this inspection while positive feedback was received from some residents' family members. The designated centre, inside and outside, was seen to be presented in a homely manner.

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

Improvements were found to be required regarding aspects of the monitoring systems in operation and the submission of required notifications.

This designated centre was registered until January 2023 and had been previously inspected by HIQA in December 2021 where a number of a regulatory actions were identified across 12 of the 13 regulations reviewed on that inspection. In response to that the provider's submitted a compliance plan response outlining the actions that they would take to come into compliance. Since then the provider had submitted an application to renew the registration of the centre for a further three years. As such the purpose of the current inspection was to assess compliance with regulations in more recent times and to inform a decision on whether to renew the registration of the centre.

As part of the application to renew the registration, the provider had submitted a statement of purpose. This is an important governance document which sets out the services to be provided to residents and which forms the basis for a condition of registration. An inspector reviewed a copy of this statement of purpose during the inspection and it was noted that it did not contain all of the information required by the regulations. This was highlighted to the person in charge and the day following this inspection an amended statement of purpose was submitted to HIQA which contained the required information.

Amongst the information contained within the statement of purpose was details of the staffing arrangements in place. During this inspection it was indicated that there five staffing vacancies and that there was a reliance on agency staff (staff sourced from an external organisation) to ensure appropriate staffing levels. Despite this it was indicated to inspectors that there were times when an assigned staff shift might not be filled in the centre. Efforts were being made to recruit additional staff for the centre and it was also indicated to inspectors that in recent months staffing situation in the centre had improved.

It was indicated that most staff employed directly by the provider had completed

relevant training although there was some gaps as referenced elsewhere in this report. For some agency staff though it was initially indicated during the inspection that the provider could not confirm if they had completed some required training as the provider did not have training certificates for these staff in their possession. The regulations require documentary evidence of accredited training of all staff are available for inspection. In the days following this inspection it was communicated by the provider that the involved agency had indicated that relevant training had been completed by these agency staff but that the provider could not verify if some of the training had been completed or not.

Staffing was an area that had been reviewed by an unannounced visit conducted by a representative of the provider in April 2022. A report of this visit was reflected in a written report and it was seen that the representative had focused on relevant areas impacting the services provided to residents with an action plan put in place in response to any issues identified. However, under the regulations such provider unannounced visits must be carried out at six month intervals but the unannounced visit conducted in April 2022 was the first such visit completed in over 11 months. Conducting such visits in a timely manner is important to assess the quality and safety of care and support provided to residents.

Providers should also ensure that there are effective monitoring systems in operation on an ongoing basis to identify and address issues relating to the services provided. In support of this it was noted on this inspection that some monitoring systems were in effect but that these required improvement to ensure that relevant issues were identified. For example, during this HIQA inspection issues around the security of medicines storage were identified but these had not been highlighted by a medicines audit completed in the centre while during this inspection it was indicated that no weekly audits of residents' personal finances were being completed despite the provider's policy in this area requiring them to be completed. In addition, it was found that there was a number of regulatory actions on this inspection including in the same 12 regulations were actions had been identified during the December 2021 inspection.

While this was area in need of improvement it was noted that management of the centre did have an awareness of relevant issues impacting this centre such as the nature of incidents occurring in the centre. However, when reviewing incident records in the centre, an inspector noticed reference in some incidents during which residents sustained some self-inflicted injuries. In accordance with the regulations and relevant guidance issued by HIQA serious injuries which require immediate medical attention should be notified within three workings days while all other injuries should be notified on a quarterly basis. While the recorded injuries noted by the inspector did not appear to be serious injuries, they had not been notified to HIQA on a quarterly basis as required.

Regulation 15: Staffing

While recruitment efforts were ongoing there was five staff vacancies at the time of this inspection and there were times when some assigned staff shifts were not filled.

Judgment: Substantially compliant

Regulation 19: Directory of residents

A directory of residents was in place that contained all of the required information such as details about individual residents and their next of kin.

Judgment: Compliant

Regulation 21: Records

Documentary evidence for some accredited training of some agency staff was not available during this inspection.

Judgment: Substantially compliant

Regulation 22: Insurance

Appropriate insurance arrangements were in place for the centre.

Judgment: Compliant

Regulation 23: Governance and management

While a six monthly provider unannounced visit was conducted in April 2022, that was the first such visit completed for this centre in over 11 months. Improvements were required in the monitoring systems in operation to ensure that they identified relevant issues while a number of regulatory actions were identified during this inspection including in the same 12 regulations were actions had been identified during the December 2021 inspection.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose provided the day after this inspection contained all of the required information.

Judgment: Compliant

Regulation 31: Notification of incidents

Not all injuries had been notified to HIQA on a quarterly basis as required.

Judgment: Not compliant

Regulation 4: Written policies and procedures

All of the required policies were in place and had been reviewed within the previous three years. Based on the findings of this inspection, the provider's policy on residents' personal finances was not being implemented in full.

Judgment: Substantially compliant

Quality and safety

While efforts were made to support residents in various areas, this inspection found that improvement was required in areas such as positive behaviour support, residents' rights and medicines.

Residents had individual personal plans in place. Such plans are required by the regulations and are intended to provide guidance for staff in meeting the assessed needs of residents. Inspectors reviewed a sample of these plans and noted that they contained a good level information on how to support residents, had multidisciplinary input and were informed by a person-centred planning process to ensure that residents and their families were involved in the review of such plans. During this process goals for residents were identified and while some goals were completed, such as going to a swimming pool, it was noted for other goals that it was unclear how they were being progressed or if they had been achieved. For example, one goal identified was for a resident to participate in online shopping but

there was no evidence in the resident's personal plan to show that work around this goal was being undertaken.

Amongst the guidance contained within residents' personal plans were information on to support resident' health needs and it was found that residents were supported to access health and social care professionals where required. The personal plans were also found to contain behaviour support plans which are important to help encourage residents to engage in positive behaviour. It was seen that such behaviour support plans provided a good level of guidance but it was noted that a signature sheet on one behaviour support plan to indicate that staff had read this plan had no entries and, while most staff were indicated as having completed relevant training, records provided during and after the inspection indicated that some had not at the time of inspection.

However, staff members spoken with during this inspection generally demonstrated a good awareness of the measures to take to support residents to engage in positive behaviour. Despite this, as referenced earlier in this report there had been an increase in incidents of a resident displaying escalated challenging behaviour and in response to some of these incidents the resident was given some PRN medicines (medicines only taken as the need arises) which had been notified to HIQA as a restrictive practice. Documentation related to this resident indicated that the resident was to be given such medicines only after all other alternatives had been tried and it was indicated to the inspectors that this was always done. However, some incidents reports in recent months made no reference to any alternatives being tried.

It was also noted from some documentation reviewed that the PRN medicines in questions were not always administered as prescribed. For example, when reviewing the administration for the resident it was indicated that on one occasion the resident had received two PRN medicines at the same time despite this not being inconsistent with specific PRN protocols in place. In addition, it was found during this inspection that the arrangements for the secure storage of medicines required improvement particularly relating to the location of keys to the medicines' press and the room where the medicines press was kept. The contents of the medicines press were reviewed by an inspector which did identify that such improvements were needed regarding aspects of the labelling of some medicines.

The use of certain PRN medicines were given following some incidents occurring in the centre where other residents would be removed from an area of the centre due to the presentation of another resident as referenced earlier. While it was acknowledged that this was being done to safeguard the other residents and staff members spoken with outlined how they did this in a respectful way, instances of residents being removed from part of the centre where they lives did impact the rights of these resident in their home. In addition, to such instances, an inspector read one incident report whereby one resident was unable to gain access to their home due to the behaviour of a peer. As a result the resident had to go to another location away from their home to change.

Efforts were made to support the resident from engaging in such behaviours with a

multidisciplinary approach being followed and it was stressed to inspectors that such incidents had not involved the highlighted resident interacting physically with their peers. However, given the nature of these incidents and the varying information given by staff during this inspection, a re-assessment was needed to determine if other residents were being psychologically impacted by such incidents. Aside from these incidents there were other incidents that had occurred in the centre in 2022 where some residents had psychically interacted with one another. Following these it was seen that relevant screenings and safeguarding plans were completed with relevant bodies notified. However, for some of these incidents it was seen that they were not reported in a timely manner. For example, one safeguarding incident was not indicated as being reported for over 3 days after the initial incident occurred.

Records provided indicated that all staff working in the centre had undergone relevant training in safeguarding. Most staff were indicated as having completed fire safety training but post inspection information received indicated that some agency staff had only completed fire safety training in the days after this HIQA inspection. The previous HIQA inspection in December 2021 had raised a particular concern around the fire evacuation arrangements for one resident and it was found on this inspection that measures had been taken to address this. Despite this the December 2021 inspection also raised some concerns around the maintenance of some fire doors and the accuracy of the fire evacuation plans on this display. On the current inspection it was again seen that the maintenance of some fire doors need review while an inaccurate floor plan that formed part of the evacuation arrangements on display in one part of the centre as seen during the December 2021 inspection remained in place.

Both of these matters were highlighted to the person in charge during this inspection and it was seen that the inaccurate floor plans were removed and replaced with correct floor plans before the end of the inspection. Regarding the fire doors, the person in charge informed the inspector that an audit of fire doors had been completed for the centre but the outcome of this was not known at the time of inspection. Aside from fire doors it was seen that the centre was equipped with other fire safety systems including a fire alarm, emergency lighting, fire extinguishers and fire blankets. Internal fire safety checks were indicated as having being completed consistently along with regular fire drills in 2022. Residents also had personal emergency evacuation plans outlining the supports they needed to evacuate if required.

Residents were being given support with their personal finances with facilities provided within the centre for residents' money to be stored securely. However, when reviewing a sample of recent records related to residents' finances, an inspector noted some discrepancies or omissions. For example, a recent receipted transaction for one resident was not recorded in a transaction log while when comparing the recorded cash balance for one resident in their transaction log against the actual cash kept for the resident it was seen that there was a different in the amounts. As referenced earlier in the report the provider was not fully implementing their own policy in this area and it was noted that the same policy indicated that monthly bank statements for residents were to be obtained. It was indicated though that some residents did not have their own bank accounts with

their disability allowance entitlements being managed by their families.

Regulation 12: Personal possessions

When reviewing records related to some residents' finances an inspector noted some discrepancies or omissions.

Judgment: Substantially compliant

Regulation 13: General welfare and development

While inspectors were told that residents participated in various activities with some residents also seen to participate in such activities on the day of inspection, that there were times when the range of activities which residents were recorded as participating in was narrow and repetitive.

Judgment: Substantially compliant

Regulation 17: Premises

The premises provided for residents to live in was seen to be generally clean, homely and well furnished. It was seen though that some areas required some painting.

Judgment: Substantially compliant

Regulation 20: Information for residents

A residents' guide was provided for that contained all of the required information such as a summary of the facilities provided and how to access HIQA reports.

Judgment: Compliant

Regulation 26: Risk management procedures

Given the nature of frequency of some incidents occurring in the centre some related risk assessments required review to determine if the residual risk ratings applied reflected the actual level of risk in the centre.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The centre was seen to be clean on the day of inspection but the cleaning records provide did not provide assurances that all areas on indicated cleaning schedules were being cleaned consistently. Not all staff were indicated as having completed relevant training in infection prevention and control. While relevant national guidance provided for twice daily active monitoring of residents for signs and symptoms of respiratory illness or changes in their baseline condition, an inspector was informed that there was no such monitoring of residents taking place.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The maintenance of some fire doors in the centre continued to require improvement while the outcome of an audit of fire doors was not known at the time of this inspection.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The arrangements for the secure storage of medicines required improvement particularly relating to the location of keys to the medicines' press and the room where the medicines press was kept. Some medicines did not have labels. Some PRNs medicines were not always administered as prescribed.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents had personal plans in place which contained a good level information on

how to support residents, had multidisciplinary input and were informed by a person-centred planning. It was noted though that for some goals it now clear how they were being progressed or if they had had been achieved.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' personal plans had information on to support resident' health needs and where necessary residents were supported to access health and social care professionals.

Judgment: Compliant

Regulation 7: Positive behavioural support

Not all staff were indicated as having read a resident's behaviour support plan while not all staff were indicated as having completed training in de-escalation and intervention. Incidents records reviewed did not always indicate if alternatives were tried before a restrictive intervention was used.

Judgment: Not compliant

Regulation 8: Protection

Some safeguarding incidents that had taken place in the centre were not indicated as being reported in a timely manner. A re-assessment was needed to determine if some residents were psychologically impacted by incidents happening in the centre.

Judgment: Substantially compliant

Regulation 9: Residents' rights

There were times when some residents were being removed from an area of the centre which reduced their rights in their home. On one occasion a resident could not access their home and had to change elsewhere.

Judgment: Not 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	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ballyseedy House OSV-0007763

Inspection ID: MON-0028682

Date of inspection: 04/08/2022

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: It is well reported nationally the current challenges in recruiting. Resilience at all times endeavor to ensure that the number of qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents. Analysis of the schedule for the week and staffing levels will be reviewed to ensure planned staffing levels are consistently met as per required standards. There is a planned and actual rota in place, in the event of staffing levels being impacted due to vacancies or sick leave the rota is adapted to reflect this. If staffing levels are impacted, adjustments to the rota are made, this may result in reduced staffing during the day. At no time has the safety of residents being impacted by roster adjustments. In the event that staffing levels are affected which could impact negatively on service users, in line with the centres business continuity plan this is escalated to the Regional Operations Manager and Director of Social Care. It is acknowledged that there may be times due to difficulties in recruiting that there is a reliance on agency staff. Every effort is made to ensure that when agency staff are being utilised that they are consistent to ensure continuity of care. Resilience has a dedicated talent acquisition team which supports the recruitment of staff. An approach of continuous recruitment is taken by Resilience and a number of initiatives such as recruitment fairs and establishing a presence in the local educational establishments have been and continue to be undertaken. There are currently three staff going through compliance once complaint they will	

commence their employment in Ballyseedy.

Ongoing review meetings are being undertaken with our agency partners in relation to providing the required documentary evidence of accredited training of staff are made available. The PIC has received certificates of training for all mandatory training for agency staff which are on file for each.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
Ongoing review meetings are being undertaken with our agency partners in relation to providing the required documentary evidence of accredited training of staff are made available.

Draft Terms of Business and service arrangements stipulate that all records and documents in relation to staff specified in schedule two are required to be compliant.

The Draft Terms of Business enables Resilience as a customer to conduct regular audits of agency staff employee files utilised by the company, the purpose of these audits is to provide assurances of compliance with the regulations.

All documentary evidence of accredited training of agency staff has been received.

Resilience will provide additional training where necessary to agency staff who are utilised on a regular basis. Requests for evidence of accredited training will be made prior to any agency staff commencing in Ballyseedy.

A training matrix of mandatory training will be maintained, and certificates held of file.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Resilience has a clearly identified management structure in the designated centre that identifies the lines of authority and accountability, specific roles, and detailed responsibilities for all areas of service provision.

Ballyseedy is supported by a full time Person in Charge, who manages two designated

centres and .75 Team Lead. The service is also supported by a Regional Operations Manager who reports directly to the Director of Social Care.

It is acknowledged that the provider unannounced visit was not carried out as outlined in the regulations. A schedule of provider unannounced inspections had been completed by the Head of Quality and Risk; provider unannounced inspections will take place as required. A written report on the safety and quality of care and support will be completed.

All actions from internal and external inspections are logged and documented with dates for compliance included. An audit of compliance of actions is completed by Resilience Quality and Risk and is reported to Resilience Quality and Safety Committee.
The Regional Manager will conduct regular review of actions from internal and external inspections to ensure that all actions are completed within the required timeframe. If there is any delay to actions being completed this will be notified to the relevant inspector advising them of the delay the reason for the delay and revised completion date. Any delay in actions identified from internal inspections being completed will also be escalated to Resilience Senior Management Team.

There is a schedule of audits in place which include but not limited to the following:

- Weekly Environmental Cleanliness Audit Tool Infection Control (Weekly)
- Mattress Audit (Quarterly)
- Hand Hygiene Audit (Monthly)
- Monthly Medication File Audit (Monthly)
- Medicines Management Audit Tool (Bi-Annually)
- Individual Support Plan Audit (Monthly)
- Service User Money Management Questionnaire (Quarterly)
- Vehicle Audit Checklist (Monthly)

Health and Safety audit checks include the following

- Daily and monthly hazard checks
- Annual Firefighting equipment audit
- Quarterly first aid checklist
- Cold storage temp check - daily
- Cold storage medication temp check- daily
- Food probing
- Weekly fridge cleanliness check
- Weekly shower checklist- for prevention of legionnaires
- Weekly fire alarm sound activation checklist

As highlighted in the report improvements were required to ensure that relevant issues are identified. All audits have an action which highlights issues identified in the audit. Action plans will be reviewed by the person in charge to ensure that appropriate and timely action is taken. Audits and action plans will be discussed and refreshed at the Person in charge meeting on the 13th of September. The responsibility of the audits and action plans have been discussed with the Person in Charge of Ballyseedy. The completion of the audits has also been discussed with the staff team.

The person in charge is aware of their requirement to report notifiable events under the regulations. All non-serious injuries will be reported on a quarterly basis going forward.

Audits will be completed on agency staff files to ensure that they are compliant with schedule two of the regulations. Training matrix of agency staff will be maintained, and certificates held of file.

Weekly audits of service users' personal finances are now being completed by the Team Leader and validated by the Person in Charge. The Regional Operations Manager will validate that audits are being completed and are accurate on a quarterly basis.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The person in charge is aware of their requirement to report notifiable events under the regulations.

All non-serious injuries sustained by all residents in Ballyseedy will be reported on a quarterly basis.

All safeguarding incidents will be reported within three working days to HIQA

Internal incident reporting and the requirement for prompt reporting of any incidents including safeguarding has been discussed with the team. Failure to report incidents within the required time frame will be discussed formally in supervision.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
Weekly audits of service users' personal finances are now being completed by the Team Leader and validated by the Person in Charge.

The Regional Operations Manager will validate that audits are being completed and are accurate on a quarterly basis.

The PIC and the Team Lead will ensure that the Service User finances are monitored and

reviewed as per policy. This will include regular review of service users bank statements.

The residents' personal finances systems have now been digitised to allow for a more robust system. A safe has been purchased for each resident and contains the debit card and petty cash belonging to each resident which is securely installed in the office.

An additional safe has been installed and will contain the PIN numbers of all the residents cash cards. The PIC and the Team Leader will only have access to the service users PIN number and bank card.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Weekly audits of residents finances are taking place, these are completed by the Team Lead and validated by the person in charge. Quarterly validation of audits will be completed by the Regional Operations Manager. Any discrepencies identifed will be explored and reason for discrepency documented. If the discrepency is not resolved this will be reported on Resilience Incident Management system and appropriate action taken.
The servcie User Finance Policy has been discussed in the August team meeting and all staff are aware of same.
The residents' personal finances systems have now been digitized to allow for a more robust system. Individual safes for each resident have been purchased to ensure that their debit cards and personal finances are securely stored.

An additional safe has been installed and will contain the PIN numbers of all the residents cash cards which can only be accessed by the PIC and Team Lead.

Ongoing discussions are taking place with service users' families to ensure that each resident has access to their disability allowance and bank account.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
The range of activities that are offered to the residents are based on their will and preferences. Routine is very important to a person with Autism and repetition of

preferred activities make occur. Each service user is encouraged to participate in various activities and given opportunity to make informed choices.

Opportunities will be provided to each resident to engage in varied activities. Choice boards, visuals and object cues are used to communicate and promote choice for each resident. This will be further developed with support from the MDT team.

The staff team will continue to record varied activities and the residents' responses to the activity offered. Staff will document if the resident choose to engage in the activity or not. Goals will be closely monitored and progress against achieving the goals or part of will be documented.

Regular reviews with the MDT take place and supporting the residents in participating in new activities will stay on the agenda for each review.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Approval for funding has been agreed and a contractor has been appointed to paint the interior of the house which is due to commence in November 2022. Due to the size of the property and limiting disruption to the residents it may take several weeks to complete.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
It is noted that there is an increase of incidents of a resident displaying escalated challenging behaviour. A review of the risk relating of incidents of behaviour of concern for one resident will be conducted by the PIC, Team Lead, PBS Specialist on the 8th of September. The risk management, controls and ratings will be reviewed in light of the increase in incidents. The outcome of this review will determine any additional supports which are to be provided.

De-escalation techniques are in place and have been reviewed (August 2022).

All staff in Ballyseedy will be made aware of any changes to current protocols and risks

Residents will only be removed from an area if the behaviour of any resident poses a risk to themselves and others. The impact of any such intervention will be clearly documented and reviewed by the PIC and the MDT.

An impact analysis will be completed on the effect of the increase in incidents on other residents in Ballyseedy. An emotions profile will be developed for each resident which will clearly document how a resident presents when they are happy, sad, frightened etc. Following any incident of behaviours of concern staff will document how any resident was impacted utilising this emotions profile. Where any resident is negatively impacted by a peer's behaviour this will be documented and reported in line with the regulations. Where this is determined to be a safeguarding concern this will be reported to all relevant statutory agencies and safeguarding plans will be reviewed/developed if required.

In addition, social stories about living with others will be developed for each service user which will support each individual to understand the people they are living with. This will be developed in consultation with the Positive Behaviour Support Specialist and Occupational Therapist.

Any restrictive practices required will be documented and reviewed in line with Resilience Restrictive Practice Policy and Procedure.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
All staff will be made aware of the need to sign the completed cleaning schedule records of each area to ensure accountability by individual staff members.

All permanent staff have completed IPC training. All agency staff will be required to have completed IPC training or facilitated to complete the IPC training before commencing on regular shifts.

The daily notes for each resident have been amended to include a section on monitoring and recording the residents for signs and symptoms of a respiratory illness twice daily as per PH guidelines.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Two sections of intumescent strip had become loose which was observed by the inspector. Works have now been completed and doors have been repaired. Resilience have engaged an external provider to conduct an audit of all fire doors in all services. The purpose of this inspection is to: • Determine the condition of the fire doors • Determine what, if any, remedial measures are required • Specify how such remedial measures, if any, should be carried out It is acknowledged due to the complexity of the services provided integrity of fire doors may become compromised over time. As additional reassurance an external audit was completed in July 2022. The report of this inspection was circulated in August and is currently being actioned by the PIC following return from annual leave. A suitable contractor has been identified and all actions from this report will be completed as a priority in consultation with our architectural services.	
Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: Arrangements for the secure storage of medicines are now in place. The lock on the door for medication storage has been replaced with a digital passcode door lock. A coded security box for the safe storage of keys to the medication storage lockers is now in place. All medicines received into Ballyseedy will be checked by the person receiving the medication to ensure that they are labelled correctly as per prescription, name, date and expiry date is correct. All medication received into the service will be counted and documented. Daily medication counts are completed which will highlight any discrepancies. During daily counts of medication, the staff member will ensure that all labels are intact and as prescribed. Medication audits will be completed in line with policy and appropriate action will be taken PRN Protocols will be reviewed by the MDT and presented to the staff team. Where there are incidents of concern which may require the administration of PRN medication staff will clearly document that the protocols were followed. All restrictive practices are recorded and reviewed in line with restrictive practice policy and procedure.	

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All residents have participated in the person-centered planning process and individual goals have been identified in accordance with the individuals will and preference. Monthly keyworker meeting take place which includes a periodic service review. The periodic service review will clearly document how goals are being progressed and if they have been achieved. The key worker recording documentation will be reviewed with all staff in particular with individual key workers to ensure that this documentation is kept up to date on a monthly basis. Records will demonstrate how residents are supported in achieving their goals

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
All Behaviour Suport Plans are presented by the PBS Specialist at team level once put in place. The beahviour support plans form part of the Induction for new and agnecy staff. The PIC and Team Lead will ensure that all PBS plans are reviewed and signed off by all existing staff and that they are disucssed with each new staff member and signed at time of induction.The signature sheet of one behaviour support plan which had no entries in it at the time of inspection has been reveiwed and is in the process of being signed by all staff, outstanding staff who have not been on shift or on annual leave will be completed on return to work.
Any outstanding MAPA has been completed with one staff Refresher MAPA training outstanding due to annual leave, which has been booked for the 7th of October., Certificates for MAPA training will be requested for any regular agency staff who commence work in Ballyseedy. If MAPA training has not been received by the agency staff member the PIC will arrange for training to be provided through Resilience.

All staff are aware of the incident reporting system and the need to report interventions used in the management of behavioural incidents. The PIC and Team Lead will ensure that all staff review the current policy on reporting of incidents paying particular attention to the need to identify and record interventions implemented prior to administration of any PRN medication.

PRN protocols are in place which have been agreed and signed off by the psychiatrist, these will be reviewed with the staff team to ensure that they fully understand the

protocol.

During induction the PIC/Team Lead will ensure that all new staff review the Incident Management Policy and examples of incident reporting discussed.

Resilience Head of Quality and Risk will attend a staff meeting in October to further enhance awareness of the incident reporting system.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All staff have completed training in Safeguarding of Vulnerable Adults and Children First.

Safeguarding and employee's obligation to recognise, respond and report any safeguarding concerns will be a recurring agenda item in team meetings and supervision. Failure to report any such concerns will be addressed formally with the individual.

An emotions profile will be developed for each resident which will clearly document how a resident presents when they are happy, sad, frightened etc. Following any incident of behaviours of concern staff will document how any resident was impacted utilising this emotions profile. Where any resident is negatively impacted by a peer's behaviour this will be documented and reported in line with the regulations. Where this is determined to be a safeguarding concern this will be reported to all relevant statutory agencies and safeguarding plans will be reviewed/developed if required. All such incidents are reviewed by the PIC and MDT.

In addition, social stories about living with others will be developed for each service user which will support each individual to understand the people they are living with. This will be developed in consultation with the Positive Behaviour Support Specialist and Occupational Therapist.

Where a residents behaviour appears to impact another this will be reported, and safeguarding plans will be reviewed or developed to ensure that all residents are protected. Appropriate actions will be agreed and taken to reduce and or eliminate the impact.

A meeting with the MDT team took place in early September to review how best to manage one individual's presentation of behaviour while limiting the impact on the other residents.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: There is a duty of care to ensure the health and safety of all residents is protected and maintained. Where the intensity and duration of any resident's behaviour presents a risk to themselves or others it may be required to request the resident to move from the immediate vicinity. This is only done as a last resort and where all other interventions have been unsuccessful. There was one occasion where a resident was unable to access their home as a result due to the behaviour of their peer. This decision was taken at the time by the PIC for safety of the individual. The resident returned to the day service building 5 minutes away. This resident is verbal, and consent was sought to return to the day service. Ballyseedy is a spacious environment and an alternative response to such incidents will be explored with the MDT.

Residents risk assessments and protocols will be reviewed and updated on how and when to intervene if necessary to request people to move to another area of the house.

It is acknowledged that it is an infringement on an individual's rights if they have not been consulted in this process, a meeting took place with the MDT for the 6th of September to review how best to support the individual rights of each service user so they are informed and supported to make choices and give consent for their own safety needs. Actions from this meeting include the development of service user specific communication such as social stories to support their understanding and specific information to be provided to staff on how best to support residents during behavioural incidents. Additionally, person centred documents will be arranged for each resident to reflect behavioural indicators of emotions so that staff supporting each resident can accurately indicate if a resident has been negatively impacted by any incidents. On-the-job training will be provided by the MDT with staff on duty to actively demonstrate the implementation of clinical plans which will be documented in each resident's file. These actions will be supported by the MDT.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	31/10/2022
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	30/09/2022
Regulation 15(1)	The registered provider shall ensure that the number,	Substantially Compliant	Yellow	31/03/2023

	qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/12/2022
Regulation 21(1)(a)	The registered provider shall ensure that records of the information and documents in relation to staff specified in Schedule 2 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	31/10/2022
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	31/10/2022

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 in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	31/10/2022
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 risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/09/2022
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting	Substantially Compliant	Yellow	31/08/2022

	procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/10/2022
Regulation 29(4)(a)	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 any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	31/08/2022
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	Not Compliant	Orange	31/08/2022

	medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	31/10/2022
Regulation 04(1)	The registered provider shall prepare in writing and adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	31/08/2022
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/12/2022

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.	Not Compliant	Orange	07/10/2022
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	07/10/2022
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 procedure is used.	Not Compliant	Orange	30/09/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/08/2022
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature	Not Compliant	Orange	31/10/2022

	of his or her disability has the freedom to exercise choice and control in his or her daily life.			
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	31/10/2022