Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Office of the Chief Inspector

Report of an inspection of a Designated Centre for Disabilities (Mixed)

Name of designated centre:	Ballytrim House
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	03 July 2019
Centre ID:	OSV-0002523
Fieldwork ID:	MON-0027111

About the designated centre

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

Ballytrim House provides both full-time and part-time residential care and support to children and adults with a disability. The designated centre comprises of a twelve bedded one-storey building located in a residential housing estate in a town. Residents living at the centre have access to communal facilities such as two sitting rooms, a sensory room, dining room, kitchen and outdoor children's play area. Each resident has their own bedroom which also includes its own en-suite bathroom. The centre's design also includes additional communal bathroom and toilet facilities. Ballytrim House is located close to local amenities such as shops, public houses and cafes. In addition, the centre has its own vehicle which enables residents to access other amenities in the surrounding area such as swimming pools and other leisure facilities. Residents are supported by a staff team of both nursing and care staff. During the day, support is provided by between six to seven staff; with at a minimum of one nurse being available at all times to meet residents' assessed needs. At night-time, residents are supported by a team of three staff members comprising of one nurse and two care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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 - 2015 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
03 July 2019	08:00hrs to 15:00hrs	Gary Kiernan	Lead
03 July 2019	08:00hrs to 15:00hrs	Conor Brady	Support

What residents told us and what inspectors observed

Inspectors were concerned that residents and children were not safe in this centre. Eight residents (including two teenage children) were observed during this inspection. Inspectors found that while residents communicated on their own terms in line with their own needs, wishes and abilities, there incidences occurring in the centre that impacted on their quality of life and safety. Residents were observed shouting, appearing afraid or excited or elated and becoming frustrated and distressed for different reasons over the course of the morning.

On arrival to this centre inspectors observed one resident sitting in the living room who was awaiting to go to their day service. One resident was running through the centre in and out of bedrooms and the staff office. Other residents were in the process of getting up out of bed. Residents were observed to require varying support needs in this centre, specific to their own individual behaviours. A resident who was in a wheelchair was observed to appear very fearful of another resident who made a hitting gesture towards them. This resident called out for staff to help as the other resident approached.

Inspectors observed a busy house with residents who demonstrated very complex support needs in terms of their physical presentation and movement through the centre. This was further reflected by the large staff presence in this centre. At one point eight staff were observed in the living room at morning handover. Staff members on duty informed inspectors that this was a 'quiet morning' and everyone was in 'good form' on the morning of inspection. Inspectors observed some interactions between staff and residents which were caring and respectful which showed that residents were comfortable and enjoyed being in the company of these staff members.

The centre was dark and not particularly homely in appearance. Despite efforts to personalise bedrooms with murals and personalised pictures, the centres layout, design and operation was observed to be institutional, bleak and in need of decoration and maintenance in some parts. For example, long dark corridors, locked doors, a high footfall of support and ancillary staff and many residents with incompatible assessed support needs were observed to be living together.

Capacity and capability

Inspectors were concerned that residents were being negatively impacted in terms of their quality of life and safety as a result of poor governance and management by provider. The centre was not a homely place to live as evidenced by frequent

(almost daily) incidents involving violence and aggression towards other residents and staff. These incidents primarily related to the incompatible mix of residents with complex and changing needs and supports. The incidents impacted not only on the residents involved but also on the other residents who lived in the centre who saw and observed what was happening. Over a prolonged period of a number of months the provider was not responding in an effective or proportionate way to alleviate the distress that these unacceptable living conditions were creating.

Inspectors were sufficiently concerned on the day of inspection and took immediate regulatory steps to address the urgent risk situation which presented. Inspectors requested HSE senior management (from the CHO area) to attend the centre at the close of the inspection and issued an urgent compliance plan to them in relation to the safeguarding and protection of children and adults. This compliance plan required the centre to address deficiencies under Regulation 8 which deals with the protection of residents and compliance with national guidelines for the protection and welfare of children. The responses submitted by the provider on 05 July 2019 did not provide the required level of assurance that the provider had taken the necessary action to address these risks. The provider was requested to submit more detail information on the actions taken to mitigate the risks and safeguard the residents in the centre. This was received on 08 July 2019 and included some assurances in relation to management arrangements and daily routines for the residents. However, it did not fully address the immediate issues of concern. In addition, due to the nature of the concerns, this centre was escalated by the Chief Inspector to the national management team in the HSE.

The provider did not demonstrate that they were effectively responding to sustained high level of incidents in the centre. Incidents records showed a pattern of incidents involving resident to resident violence and self injurious behaviour which had been sustained over a number of months. There was a significant impact on the residents which ranged from physical assault, hitting, slaps, pushes, to incidents of a safeguarding nature which are addressed in the next section of this report. Staff members were also impacted with a number on leave due to occupational health injuries at the time of inspection. The provider had taken some actions to address this situation. At a recent multi-disciplinary meeting In May 2019, which involved staff, management, representatives of TUSLA - the Child and Family Agency and other health care professionals a decision was taken to halt respite admissions to the centre. An "immediate action plan" was drawn up by the provider and while some aspects of it had been implemented, ultimately the steps taken did not address the issues of concern. As a result residents continued to live in a chaotic and fearful environment as observed at the time of inspection.

Inspector were concerned that the local management arrangements did not provide adequate governance and oversight. The person in charge was not based in the centre and staff said that they did not have frequent contact with them. They were not present in the centre at the time of this inspection. A clinical nurse manager (CNM) reported directly to the person in charge and was assigned to deputise for them. It was evident that this person knew the residents' needs very well. However, due to the absence of nursing staff their time was primarily taken up with routine nursing duties and working directly on the floor. As a result

management arrangements required review to ensure they were responsive to the high level of need in this centre. It was evident that the provider had made arrangements for some additional management input and support from members of the Quality, Safety and Risk team. One of these managers were present in the centre at the time of inspection and seen to be providing support to the CNM.

Inspectors were concerned that risk management and response procedures and process was not sufficiently adequate to ensure residents were safe. The provider did not have adequate assurance mechanisms in place and was not maintaining adequate oversight of the centre. Internal HSE processes for communicating and escalating incidents and for managing risks which occurred in the centre were not being adhered to. The provider did not have the appropriate assurance mechanisms in place to ensure that these procedures were being followed. This was a critical area of oversight given the high volume of incidents and risk identified which were known about in this mixed centre for children and adults. Risk management is addressed in the next section of this report

The provider's audit, annual review and unannounced visits processes were not effective. The provider was not using the information from these mechanisms to gather accurate information about the centre and to implement improvements. Inspectors were shown records of an unannounced inspection carried out by the provider and an annual review of the quality and safety of care. Both documents were dated March 2109. Based on the inspection findings, it was evident that these documents were not reflective of conditions in the centre or of the lived experience of the residents. Inspectors were informed that the provider had recognised the deficiencies in these processes and two staff members had been assigned by the provider to repeat these reviews. This process had not commenced at the time of inspection. There was a schedule of audits to be carried out in areas such as medication safety, but inspectors were told that they had not been completed in recent months due to time and resource constraints.

Inspectors found the provider failed to implement action plans which they had undertaken to implement. Following the previous inspection in November 2018, the provider undertook to provide separate accommodation for children and adults. This was also part of the provider’s recently developed quality improvement plan. This action had not been implemented and as a result children continued to be accommodated inappropriately and continued to at risk of abuse from older adult residents. Inspectors found that this living arrangements was not appropriate or safe for these children.

The provider did not demonstrate the capacity and understanding to notify the Chief Inspector of incidents involving residents in line with the requirement of the regulations. This was also the case in relation to information which involves children. While inspectors were told by management that some information was verbally being passed on to TUSLA - the Child and Family Agency, this was not recorded or reported in line with Children's First requirements or the centres own prescribed mechanisms and channels for reporting such concerns.

Inspectors saw many positive interactions between staff and residents. It was clear

that individual staff members cared about the welfare of the residents and notwithstanding the difficult working conditions they were committed to their roles. However, the provider was not managing the staffing resource appropriately. While the numbers of staff were adequate at some points of the day, there were times when numbers of staff required review. For example, when inspectors arrived in the centre at 8am it was evident a resident who the provider had identified as requiring 2 to 1 support was not in receipt of this. The skill mix of staff also required review. The provider had identified the need for additional nursing staff during the day however this has not been addressed. This had an impact on residents' general welfare as described in the next section of this report.

The provider had also failed to ensure that the staff team had been provided with the appropriate training and gaps were noted in key areas such as safeguarding, Children's First and positive behavioural support. The provider had also failed to implement staff supervision. This meant that a structure to facilitate ongoing staff development and support was not in place.

Complaints were not being adequately responded to. Inspectors saw that a number of complaints had been received since the start of 2019. Some of these related to the quality and safety of care provided to residents. In a number of the examples reviewed by inspectors it was not evident that the provider had responded adequately or proportionately given the serious nature of the issues raised. Therefore it was evident that the provider was not acting on feedback to address issues in the centre.

Regulation 14: Persons in charge

The person in charge arrangements in place in this centre were not effective in ensuring the effective governance, operational management and administration of the designated centre.

Judgment: Not compliant

Regulation 15: Staffing

The staffing arrangements in the centre were not meeting the needs of the residents and required review. There specific times of the day when the staffing requirements as assessed by the provider were not being met. The staffing arrangements were not facilitating residents to leave the centre and participate in their community.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had not ensured that the staff team had been provided with the training and knowledge to meet the presenting needs of this group of residents. The system of staff supervision and support had not been implemented.

Judgment: Not compliant

Regulation 23: Governance and management

The centre was not governed and managed effectively. The management systems in place were failing to respond to the sustained and unacceptable conditions in the centre. Effective and timely action was not taken to address and alleviate the distressing living conditions which residents were experiencing over a prolonged period of time.

The provider did not demonstrate that they could take effective, proportionate and immediate corrective action when immediate concerns were communicated to them at the close of this inspection.

The provider did not demonstrate the capacity to implement action plans put in place following previous inspections.

The provider's oversight of the centre in terms of audit, annual review and unannounced visits was not effective.

Judgment: Not compliant

Regulation 31: Notification of incidents

The provider failed to comply with the regulatory requirement to notify incidents involving residents to the chief inspector.

Judgment: Not compliant

Quality and safety

The arrangements for the adults and children living together in this centre were not safe or appropriate. Residents in this centre have very complex support needs and displayed many behaviours of concern. Inspectors observed that there were compatibility issues between the residents and children that made it unsafe for them to be living together. Inspector were concerned that the provider had not reviewed the current living arrangement and taken the necessary actions to improve the quality of life and safety for residents.

Inspectors were not satisfied that the children living in this centre were adequately safeguarded. All staff spoken with told inspectors that residents and children were not safe in this centre. Inspectors observed a child who appeared fearful of another (adult) resident. Inspectors heard her scream for help when this resident approached her and made a hitting gesture towards her. In reviewing the incident and accident records and discussing this matter with staff, it was found that this child was hit/assaulted by this other (adult) resident on a number of occasions. When questioned about the incident report documentation, staff told inspectors that because this child was in a wheelchair and had limited mobility she was an 'easy target' and 'gets hit and targeted a lot'.

Incident reports indicated that an adult male resident 'stripped naked' in front of a female child resident in March 2019. In discussing this incident with management and staff the inspectors found a number of very concerning failings. A safeguarding plan to protect the child was not put in place. The matter was not reported by the designated centre in line with Children First and/or the centres HSE Child Safeguarding Statement and therefore was not investigated in line with same. In discussing this incident with staff and reviewing documentation in the centre inspectors found that this was not an isolated incident and had occurred previously whereby adults 'stripped' in front of children. Most staff spoken with highlighted this concern (and other concerns) to inspectors.

Risks were not being managed safely in this centre. Residents and children living in the centre were at risk as a result of this absence in effective risk management practice. For example, a serious incident took place in this centre in May 2019 that required Garda intervention as staff were no longer able to manage the severity of the behaviours. This incident was reviewed and involved very volatile, violent and aggressive behaviours that affected others living in the centre. This serious incident was witnessed by children living in the centre. A number of records seen showed that some residents presented as anxious and upset because fo the incidents they had witnessed.

Management reported to inspectors that there were 42 active safeguarding issues being investigated at the time of inspection. Inspectors were concerned that this was not an accurate number, based on their review of the safeguarding data available. This issues was further compounded by the absence of coherent oversight and management of safeguarding and the serious inconsistencies in recording and reporting of same.

In addition to the safeguarding and protection concerns to residents and children in this centre, inspectors also noted that staff were at risk in this centre. Inspectors were informed that multiple staff were absent from the roster due to 'work related injuries' and all staff spoken with had been subject to assault. Documentation reviewed by inspectors included 225 (approximately) incident reports on record since January 2019 and based on inspection findings possible under reporting of incidents was occurring as staff said that near misses are not recorded in the centre. A clinical nurse manager (CNM) from the HSE's Quality, Risk and Safety department had been recently seconded to the centre to retrospectively review and correlate the reports of accidents and incidents and ascertain the those that required further action and reporting. Inspectors were informed that this process had commenced only two week prior to this inspection.

Based on the findings of the inspection, inspectors were not satisfied that staff had good knowledge and understanding of safeguarding. Further staff training, development and supervision was required in the areas of understanding Childrens' First, adult safeguarding and reporting guidelines. For example, gaps in knowledge were evident in some staff members' knowledge of the types of abuse and reporting and recording mechanisms. Inspector were sufficiently concerned about the children living in this centre that a referral was made to Tusla following this inspection.

As outlined in the previous section of the report, systems of risk oversight were found to be completely inadequate and ineffectual. Arrangements for the identification, recording, investigation of and learning from serious or adverse events and incidents involving residents and children were not effectively reducing these risks to residents and children. It was also evident that identified risks were not being managed in accordance with the provider's own procedures. For example, the risk of violence and aggression had been rated as very high in the centre's risk register. However, it was not demonstrated that this risk had been escalated and assigned to responsible persons in line with the HSE risk policy.

The arrangements observed and reviewed in this centre regarding risk control measures were not proportional to the risks identified and quite often the risks were so commonplace that they were not being identified in the first instance. Risk impact on residents' and children's quality of life was found to be significant in this centre. For example, a resident identified and assessed as posing a significant risk to others had been recently moved to another part of the centre following a multidisciplinary review. In addition, this resident was to be allocated 2:1 staffing. This resident was not being supported by 2:1 staffing when inspectors arrived unannounced at this centre and was observed threatening another resident, running through the centre including staff offices and other residents' bedrooms. These observations demonstrate that while a risk was identified, the assessment and control measures implemented were ineffective.

The review of extensive incident and accident records by inspectors indicated that very significant gaps in incident recording and reporting. For example, the quality, safety and risk staff member told inspectors that a recent review showed that a possible 100 reported incidents (2019) had not been escalated either to HSE

Adult Safeguarding (adults) or TUSLA - the Child and Family Agency (children) in line with national requirements. There was no system of appropriate reporting in place to the children's allocated social workers.

Inspectors reviewed multidisciplinary meeting minutes dated 16 May 2019 whereby an 'immediate action plan' focused on child protection and safeguarding was devised by the provider in response to the incidents occurring in the centre. The inspectors found that these measures were implemented on the date of inspection.

In reviewing behavioural support plans (which required clinical review and updating) residents were not being supported in line with these assessments. For example, residents assessed as requiring a low stimulation environment was observed becoming very elated and distressed as eight staff completed a handover in front of them in the living room. Observations over the course of inspection indicated a very loud and busy environment with eight residents who all presented with very different but equally complex support needs. This resulted in a very challenging environment for staff to support residents and while assessments were in place that indicated the need for a low arousal environment this was not observed. Inspectors noted ongoing usage of prn (as required) medicines administered to 'regulate behaviours' in this centre. All alternatives were not observed to be considered in such cases. For example, the provision of a lower stimulating, less hostile and quieter environment in line with these residents' behavioural support plan guidance.

Residents' general welfare and development was found to be comprised in this centre. This was in many ways linked to the frequency and severity of incidents and incompatibility of residents and children in the centre. This caused a reactive and responsive approach to service provision that was largely crises focused whereby staff were regularly dealing with incidents and near misses. As a result inspectors found that residents who displayed the most severe behaviours were often prioritised in terms of staff allocation to go out on activities/outings as a risk management strategy. This approach left a number of residents who did not have day services, regular activities/programmes not being prioritised in terms of their individual needs and quality of life. In addition, residents with epilepsy could often not leave the centre due to the staffing arrangements in place for the administration of emergency epilepsy management medicines.

Regulation 13: General welfare and development

Residents general welfare and development was significantly compromised in this centre. Some residents had access to day services while others did not.
Some residents had the staffing support levels to leave the centre on activities while others did not. The provision of services was largely based on behaviours prevalent in the centre and reactive responding to accidents, incidents and near misses..

Judgment: Not compliant

Regulation 26: Risk management procedures

Risk management procedures were not effective in terms of the assessment, management and oversight of risk in place. Identified risks were not being mitigated by appropriate control measures. Furthermore, identified risks, accidents and incidents were not being appropriately reported, recorded or escalated.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Individual assessments reviewed were found not to be accurate and updated in line with the assessed and changing needs of residents.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Positive behavioural support plans in place were not observed to be implemented. Plans required clinical review and update. Restrictive practices reviewed did not consider all alternatives prior to use.

Judgment: Not compliant

Regulation 8: Protection

Residents and children were not safe or appropriately protected in this centre. National guidance for the protection of children was not adhered to.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents rights were significantly compromised in this centre.
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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ballytrim House OSV-0002523

Inspection ID: MON-0027111

Date of inspection: 03/07/2019

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 14: Persons in charge	Not Compliant

Outline how you are going to come into compliance with Regulation 14: Persons in charge:
The provider has ensured that a new Person in Charge has been appointed for this centre and is based in the centre Monday to Friday 9am-5pm.

This person has an appropriate qualification in healthcare, has completed the Person in Charge (PIC) Management Course and has 9 years relevant experience in a supervisory role in Intellectual Disability Services.

The person is fulltime, and is currently being supported and mentored by the Area Co-ordinator and the Provider Representative. All schedule 2 documentation is in place with the exception of garda vetting which has been reapplied for 22.07.2019.

The person in charge is knowledgeable about the requirements of the Health Act 2007, regulations and standards and her role therein.

The PIC will ensure that Regulatory compliance is assessed and monitored using a self-audit tool and corresponding quality improvement plan to address deficits and drive quality improvement initiatives within the centre.

Two experienced managers have been assigned to the centre to work alongside the Person in charge for a period of 2 weeks commencing August 7th 2019 in a supportive role, given the centre's current status.

Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
A Staffing review has been conducted to ensure that the number and skill-mix of staff are appropriate on a daily basis to meet the number and assessed needs of the residents, the statement of purpose, and the size and layout of the centre. An additional staff member has been added to the roster to ensure the needs of children are being met in terms of both protection and facilitating daily activities.
In relation to identified vacancies approval has been received for the replacement of 2 staff nurses and 4 Healthcare assistants. Human Resource Department has offered the approved posts to current panels and this will be monitored by the registered provider until posts are filled.
There is a planned and actual staff rota in place which is properly maintained and displays staff on duty during the day and night for this centre.
All information and documents specified in Schedule 2 of the regulations has been obtained in respect of all staff in the centre.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
A review of staff training has been conducted to identify deficits in this area. A scheduled plan has now been developed to address deficits identified.
3 staff require to update their children's first training and have been requested to complete same on line within a specified timeframe.
5 staff has completed refresher safeguarding training and a further 2 dates have been identified for the week commencing 12th and 19th August for all other staff including regular agency staff working in the centre to ensure all have up to date safeguarding training.
5 staff has completed Studio III training on 26th, 29th and 30th July 2019.
A further 3 staff who require Studio III training are scheduled to complete same on 12th, 13th and 14th August 2019.
5 staff require refresher fire training. 3 Staff are scheduled to complete same on 19.08.19. The remaining two will be trained by 30.8.2019
The centre's staff training matrix has been updated to reflect the current position and the PIC will monitor staff training to ensure training and refreshers are completed within the required timeframes
A schedule for Staff Supervision has been completed. 4 staff supervisions are scheduled for completion by 12.08.2019, 8 supervisions are scheduled for 30.08.19 and 5 are scheduled for completion by 30.09.2019.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
A self-assessment of this centre was completed against all Regulations using the assessment judgement framework, was completed on 4.07.2019 and a site specific quality improvement plan with identified timeframes has been developed.

This quality improvement plan is being monitored weekly by the Provider Representative, General Manager's Office and the Head of Social Care.

Twice weekly meetings are scheduled with staff to progress quality improvement plan actions and to ensure staff are fully informed. Updates in this regard have been provided to staff on duty on 25.07.19, 02.08.19.

The Head of Social Care, Regional Director of Nursing & Provider Representative held a Staff meeting on 9.07.2019 to discuss the outcome of the recent inspection, actions required and discuss any concerns that staff wished to raise. A schedule of fortnightly staff meetings has been developed and are now taking place. Minutes available

A review of staff training has been conducted to identify deficits in this area. A scheduled plan has now been developed to address any deficits identified.

A schedule for Staff Supervision has been completed for the centre.

The Registered Provider is conducting onsite visits to the centre a minimum of 3 times weekly.

Senior Management has conducted weekly and will continue to conduct weekly unannounced visits from a governance perspective to ensure effective and timely action is taken on all aspects of the running of the centre.

The annual review of the quality and safety of care and support for the centre will be conducted by the registered provider and supported by the Regional Director of Nursing. Residents will be consulted with as part of this process.

A six monthly unannounced visit to the centre has been conducted and actions arising from same have now been added to the centres overall QIP.

A review of audits within the centre has been undertaken. A new audit schedule has been introduced and the PIC will monitor weekly to ensure that any action outcome of audits is followed through.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
A look back review of notifications have been undertaken from 1st January 2019. All retrospective notifications have now been completed and submitted to the regulatory authority. Copies of all notifications are available in the centre for inspection.

A look back review of all child notifications has been undertaken from 1st January 2019. All retrospective notifications have been completed and submitted to TUSLA. Copies of all notifications are available in the centre for inspection.

A look back review of incidents have been undertaken from 1st January 2019.
Any further required retrospective notifications will be submitted based on the findings of this review. Copies of all incidents are available in the centre for inspection.

A monthly audit of incidents will be conducted by the PIC. This will be supported by CNM3 Quality, Risk & Safety.
The provider will review the effective management of notifications during the Regulation 23 provider visits and reviews.
The provider has re-issued a memo with the monitoring of notification handbook 2018 attached to all staff working in designated centre's to ensure all staff as appropriate are aware of the requirement for regulatory notifications.

Update:

A look back review has been undertaken for the period from 1st January 2019 to 25th June 2019. This incorporated adult notifications, child notifications and all incidents within the centre.

All retrospective notifications identified in this review have been completed and submitted to the relevant bodies; HIQA, TUSLA, the Safeguarding & Protection Team and the Health and Safety Authority.

Copies of all notifications are available in the centre for inspection.

In recognition of the failure to submit notifications within the regulatory time frame, the provider has:
• Brought the monitoring of notification handbook 2018 to the attention of all staff and provided each staff member with a copy of same.
• Implemented monthly audit of incidents which is supported by CNM3 Quality, Risk & Safety – completed 28/08/2019 (for July) and 07/09/2019 (for August)
• Effective management of notifications will be a focus of attention by the Registered Provider during the Regulation 23 provider visits, review and all senior management visits to the centre
• A clear process for daily review of nursing reports and incident forms is now in place

which informs notifications as required.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
Day Service staffing deficits have been addressed to ensure regular attendance at Day Services for the residents at this centre.
From 03.07.19 an additional staff has been added to the roster daily to provide greater opportunity for the children residing in the centre to engage in activities of their choosing. One of the children availed of July school summer camp.
A schedule of community activities has been developed and implemented for the second child.

A full review of three residents' individual activity schedules has been completed. A scheduled for the review of the remaining six residents' activity schedules is now in place as part of the residents annual person centred plan review. Records are maintained of all activities availed of. A named nurse and keyworker is assigned to each individual.

An audit of all person centred plans has been completed 29.07.2019.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A full review of all risks within the centre is currently being undertaken and will be completed by 09.08.2019.

A centre specific protocol has been developed and implemented for incident management within the centre on 15.07.2019 to ensure that all identified risks, accidents and incidents are being appropriately reported recorded or escalated. Post incident reviews with staff and relevant MDT members have commenced on the 10.07.2019. A post incident review protocol has been developed and the Principal Psychologist is facilitating the post incident reviews that meet the threshold in the interim until a core group of staff are trained on September 5th 2019.
Quality Safety & Risk Meetings are now scheduled to be held monthly to review incidents at the end of each month and identify areas for improvement and share learning to

prevent reoccurrence.

All residents individual risk assessments are being reviewed and updated as part of the review on each residents person centred plan. Completed by 12.8.2019

The CNM3 for Quality, Risk & Safety will support the PIC with the completion of audits in this area.

Update:

A post incident review protocol has been developed and the Principal Psychologist facilitated post incident reviews that meet the threshold as per the criteria below in the interim pending the training of a core group of staff (to include Social Worker, Director of Nursing, CNM2, CNM3 and Nurse Practice Manager) which was completed on September 5th 2019. A process for facilitating ongoing post incident reviews is now in place.

In consultation with the Principal Psychologist it has been agreed that the criteria for post incident reviews includes that:
• Someone has been injured
• There is a pattern of behaviours
• The staff member involved in the incident or another staff member has requested the review
• The current behaviour support plan is not addressing the behaviour.
Post incident reviews with staff and relevant MDT members commenced on the 10/07/2019 with reviews completed on August 12th, 13th, 21st and 29th 2019. A further post incident review is scheduled for Thursday Sept 12th 2019.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
An audit of all residents' individual assessment and person centred plan was completed 29.07.2019.

Work has commenced on all actions identified through the audit and will be completed by 12.08.19. Following completion of actions identified, all residents will have a comprehensive assessment of need completed and a personal plan with the maximum participation of the resident. Each residents personal plan will reflect the supports required to maximize the residents' personal development in accordance with the residents' wishes. A schedule of annual multidisciplinary reviews has been developed.

Personal plans are made available to residents in an accessible format.
Individual support plans and risk assessments will be evaluated on a quarterly basis or more frequently should the need arise.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
All Positive behaviour support plans have been reviewed by Clinical Psychology.
Staff Information sessions are scheduled for 7th & 8th August specifically in relation to the observation and implementation positive behaviour support plans for residents within the centre. Post incident reviews with staff and relevant MDT members have commenced on the 10.07.2019. A post incident review protocol has been developed and the principle psychologist is facilitating the post incident reviews that meet the threshold in the interim until a core group of staff are trained on September 5th 2019.

An assessment of restrictive practices used within the centre will be undertaken and existing restrictive practice protocols reviewed to ensure all alternatives are considered and the least restrictive practice is implemented for the minimum amount of time and accurate records are maintained of same.
Additional Psychology resources have been allocated to the centre.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The HSE have considered options in relation to residential provision for the two children living in Ballytrim. A number of external options have been considered in addition to formally separating the children to an area within the centre.
The option of separation of the children within the centre with a dedicated staff team has been agreed as a short term measure. The medium term and long term option is to relocate the children to an external facility which will be funding dependent. Full consultation with TUSLA has taken place regarding these options.

In the interim an additional 1 WTE staff resource has been added to the roster to ensure the immediate safety of the 2 children residing in the centre. An application for regular respite breaks for one young person has been completed.

Weekly MDT Safeguarding meetings have commenced on June 14th 2019. Safeguarding

plans have been developed for each person living in the centre and are discussed at weekly meetings. TUSLA have commenced weekly visits to the centre. All allegations or suspicions of abuse are notified to HIQA.
All incidents involving children are notified to TUSLA and all retrospective notifications have been completed and submitted to the regulatory authority and TUSLA as appropriate.

The provider has re-issued a memo with the monitoring of notification handbook 2018 attached to all staff working in designated centre's to ensure all staff as appropriate are aware of the requirement for the regulatory notifications.

A review of staff training has been completed to identify deficits and a scheduled plan is in place to address same. Safeguarding training to include Children First is mandatory for all staff.
All allegations or suspicions of abuse are investigated and reported in line with policy.

The HSE Open Disclosure Policy is implemented within the centre.

Safeguarding is a standing agenda item at residents meetings.

All positive behaviour support plans have been reviewed by Clinical Psychology.
Staff information sessions are scheduled for 7th & 8th August specifically in relation to the observation and implementation of positive behaviour support plans for residents within the centre. Post incident reviews with staff and relevant MDT members have commenced on the 10.07.2019. A post incident review protocol has been developed and the principal psychologist is facilitating the post incident reviews that meet the threshold in the interim until a core group of staff are trained on September 5th 2019.

Update:

As of 12/08/2019 the layout of the centre has been amended to allow for physical separation of the children within the centre with a dedicated staff team in place. On going consultation with Tusla continues to ensure the effectiveness of the arrangements and that the best interests of children are maintained

In addition to ensuring that all residents are protected from abuse, all positive behaviour support plans have been reviewed by Clinical Psychology as of 13/08/2019.

Psychology facilitated staff Information sessions on 7th & 8th August 2019 specifically in relation to the observation and implementation positive behaviour support plans for residents within the centre.

Post incident reviews with staff and relevant MDT members have commenced on the 10/07/2019.

Safeguarding plans have been developed for each person living in the centre and are discussed at weekly centre meetings. TUSLA continue to provide weekly visits to this centre. All allegations or suspicions of abuse or neglect are notified to HIQA and the HSE Safeguarding and Protection Team. All incidents involving children are notified to TUSLA .

A full review of notifications has taken place and any retrospective notifications have been completed and submitted to the regulatory authority and TUSLA as appropriate.

MDT Safeguarding meetings commenced on June 14th 2019 and continue weekly.

Refresher Safeguarding Training was completed as per submission on 12/08/2019 and 19/08/2019 with a further 2 dates scheduled for 11/09/2019 and 24/09/2019.

The HSE Open Disclosure Policy is implemented within the centre. Dates for training have been confirmed for 18/09/2019 and the 25/09/2019
Safeguarding continues to be a standing agenda item at residents meetings.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Residents are consulted with on a daily basis with regard to the running of the centre.
A schedule of monthly residents meetings has been developed. Residents meetings have been held on 13.07.19 and 03.08.19
Residents Rights are a standing agenda item at residents meetings.
Residents and their representatives are invited and encouraged to participate to a maximum in the resident's annual review meetings.
An Identified Keyworker for each resident will ensure that the review of Individual person centred plans will include as much as possible, the views of the residents and will reflect their individual preferences.

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
13 (1)	Provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	12/08/2019
Regulation 14(2)	The post of person in charge shall be full-time and shall require the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.	Not Compliant	Orange	09/07/2019
Regulation 15(1)	The registered	Not Compliant		06/09/2019

	provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.		Orange	
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	30/09/2019
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/09/2019
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	Red	26/07/2019
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review	Not Compliant	Orange	30/09/2019

	of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.			
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.	Not Compliant	Red	26/07/2019
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	01/08/2019
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently	Not Compliant	Orange	12/08/2019

	as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
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	20/08/2019
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Red	26/07/2019
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	09/08/2019
Regulation 08(2)	The registered	Not Compliant	Red	05/07/2019

	provider shall protect residents from all forms of abuse.			
Regulation 08(5)	The registered provider shall ensure that where there has been an incident, allegation or suspicion of abuse or neglect in relation to a child the requirements of national guidance for the protection and welfare of children and any relevant statutory requirements are complied with.	Not Compliant	Red	05/07/2019
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Not Compliant	Orange	22/08/2019