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:	Coolamber House
Name of provider:	St Hilda's Services
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	07 October 2021
Centre ID:	OSV-0001836
Fieldwork ID:	MON-0029061

About the designated centre

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

The statement of purpose for the centre outlines that this seven day fulltime residential community house provides a home for three adults, male and female with moderate intellectual disability, behaviours that challenge and dementia. There is one-to-one staff support provided and two staff available at night time. Nursing oversight is available as part of the staff team and within the organisation. The premises is a two story detached house, on its own grounds, and comprises of a communal kitchen, living room and laundry room. There is one self-contained apartment located in the centre consisting of a large bedroom, en-suite facilities and living room. The second resident's bedroom consists of a large bedroom and en-suite facilities. The third resident's bedroom and separate bathroom are located in the main part of the centre. There is one staff bedroom and one separate office space. The centre is located in large town within easy access to all services and amenities

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 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
Thursday 7 October 2021	09:40hrs to 18:45hrs	Florence Farrelly	Lead
Thursday 7 October 2021	09:40hrs to 18:45hrs	Karena Butler	Support

What residents told us and what inspectors observed

The inspection took place in a manner so as to comply with current public health guidelines and minimise potential risk to the residents and staff.

Inspectors met with all three of the residents on the day of inspection and were greeted by two residents at the door upon arrival. One resident left the centre shortly after inspectors arrived to attend a separate day programme. Prior to leaving the resident told inspectors that they liked their house and their room. They said staff involved them in daily decisions about their life and the running of the house and they felt staff listened to them. This resident came back to the centre shortly before the end of the inspection and told inspectors they had a good day. The resident was observed relaxing, having a takeaway while watching the television when inspectors were leaving the centre.

Another resident chose to have a lie on that morning and not attend their scheduled day programme and staff were supportive and respectful of this decision. They relaxed in the house for some of the day and went out for a walk and a drink with staff and another resident. The third resident relaxed in the centre for part of the day, completed some house chores which they seemed to enjoy and also went out for a drive and coffee. This resident liked to dress smartly, the resident changed their outfit a number of times during the day and proudly modelled these outfits for inspectors to admire.

One resident expressed to inspectors that they no longer wished to live in the centre. They said that while the house and staff team were nice, they would prefer to live in a different house near their parents. The resident stated that there were incompatibility issues between them and another resident living in the house which meant that this resident did not always feeling safe or comfortable in the centre. This was confirmed by staff and a member of the senior management team who informed inspectors that there were in the process of supporting an alternative placement for this resident. To that end a meeting has taken place in April 2021 and a further meeting was scheduled to take place in the coming weeks in the hope to plan and progress a transition to a new home for this resident.

Each resident had their own bedroom and own bathroom. The three residents agreed for inspectors to see their bedrooms and one resident chose to give a tour of their room. Rooms were observed to be spacious and decorated to take into account their individual style and preferences. For example, one room contained personal items such as football memorabilia and football pictures of the resident's favourite club. All rooms were painted in colours chosen by the residents themselves and contained personal family pictures. In each of the rooms there was adequate storage for their clothes and personal belongings. One resident had a football table (table football) in their personal sitting room. The communal sitting room contained an air hockey table.

The centre had a spacious front and back garden. However, while the front garden was decorated to a good standard with lots of plants, the back garden space was not being used to its full potential and did not appear a welcoming space. It had a small area with uneven paving and a picnic table and seating with patchy and flaking paint. There was a large shed that required some repair and a large grass area with no plants or leisure equipment for residents use. A staff member spoken with informed one of the inspectors that one of the resident's liked to go out to play football on the grass however, this was not an inviting space for them.

There were two care staff on duty in the centre on the day of inspection and they were very knowledgeable on the residents' preferences and supports required. Inspectors observed interactions at different times throughout the day where staff communicated with and supported residents in a respectful manner. Residents appeared relaxed in their company through their interactions and facial expressions.

Residents were involved in the running of the centre such as through residents meetings and these were held weekly in the centre with a number of areas being discussed. Areas included, dignity and respect in the house, house chores, weekly activities and COVID-19 management.

Overall, residents reported they received a good quality of care and support in the centre, the care being delivered was person centre and appropriate to meet the needs of residents and staff appeared to know the residents well. However, there were improvements required in relation to the governance and management, written policies and procedures, records, staffing, staff training and development, notification of incidents, individual assessment of personal plans, healthcare, positive behavioural supports, premises, risk management, protection against infection and fire precautions.

The next two sections of this report present the findings of this inspection in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being provided.

Capacity and capability

The governance and management arrangements in the centre were not effective in ensuring the service was operated in compliance with the regulations and standards and ensuring a quality safe service was delivered to residents. While inspectors found the centre was adequately resourced as stated earlier improvements were required in relation to written policies and procedures, records, governance and management, staffing, staff training and development and, notification of incidents. These areas will be discussed in this section. Improvements required in other areas will be discussed in section two of this report.

There was a defined management structure in place which included a suitably qualified person in charge who worked on a full-time basis across two designated

centres. The person in charge was not on duty the day of the inspection therefore the inspection was facilitated by a senior manager and a team leader who seemed to know the residents well and could answer any queries from the inspectors.

While it was demonstrated the provider had systems in place to meet aspects of Regulation 23, in terms of carrying out an annual report and six-monthly provider led audits, it was not demonstrated that oversight arrangements in the centre were effective due to a number of regulatory non-compliance's and substantial-compliance's found on this inspection. For example, the provider had not obtained all of the information required in relation to staff specified in Schedule 2 of the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations). The majority of written policies and procedures that guide staff practice in the centre were out of date. Residents' positive behaviour support plans were not all in date this would mean that staff may not have the most up-to-date guidance in order to support the residents. Fire containment for the hot press would not adequately protect in the event of a fire. Residents' files were not maintained in a manner for staff to adequately support the residents and up-to-date information was not always easily accessible. The person in charge had not always ensured that staff had access to refresher training.

There were local audits and reviews conducted in areas, such as incident management and health and safety and from a sample of audits viewed for the most part necessary corrective actions identified had been addressed by the provider. However, the uneven back garden paving and garden shed had been identified on a provider audit as requiring repair and this was yet to happen at the time of inspection. In addition an audit had identified that staff required training in a particular area in order to support one of the resident's, while the majority of staff had received this training, the person in charge had not followed up regarding two staff still outstanding for this training since July 2021. The provider had progressed an action from the last compliance plan with the installment of a fire door for the hot press. However, the door still required an intumescent strip or cold smoke seal around the door in order to resist the passage of fire and smoke in the event of a fire.

While the provider did have all the required Schedule 5 policies and procedures in place and they were available at the centre, they had not been reviewed at intervals not exceeding three years. Additionally food safety was not included in any policies as prescribed by Schedule 5 of the regulations.

From a review of records within the centre there were improvements required to residents' files to ensure the most up-to-date accurate information was easily accessible. Not all review schedules in place for restrictive practices had the name of the resident or their date of birth documented. This posed a risk that the incorrect intervention could be put in place for the wrong resident which had the potential to impact on residents' safety and supports required if staff were not accessing the most relevant information. Improvement was also required to the recording of complaints with regard to timing and dating actions to ensure actions were closed

off appropriately and within reasonable time frames.

From a review of the staff rosters inspectors could see that there was a planned and actual roster in place that was maintained by the person in charge. There was a consistent staff team employed in the centre with the addition of two new staff having been employed over the previous few months. There were sufficient staff on duty to meet the assessed needs of the residents. Inspectors noted an increase in staffing levels on certain days in the week in order to meet the needs of a particular resident. However, there was a gap observed by an inspector on the roster for one required sleepover shift for the week after the inspection.

Inspectors reviewed a sample of staff files with respect to records required under Schedule 2 of the regulations, the provider had not obtained a full employment history for all employees as some records related to staff did not have specific dates of employment which made it difficult for an inspector to ascertain if there were any gaps in employment history. Inspectors found in the case of one staff member, that the provider had not obtained a reference from their most recent employer. One staff contract viewed did not state the number of hours the person was employed for each week. One staff file did not contain evidence of the person's identity or a recent photograph. This missing identification was rectified by the end of inspection and evidence of it in the file shown to an inspector.

Staff spoken with told inspectors that they felt supported in their role and were able to raise issues or concerns, where necessary, to the person in charge. Staff supervision records were not viewed on this inspection. Monthly staff meetings were occurring in the centre and from a sample viewed the agenda items discussed included resident updates/supports, safeguarding, reflection on practice, risk management, management of COVID-19 and, health and safety.

The staff training records showed that staff were provided with a number of training opportunities to enable them to safely perform their roles and responsibilities. These included safe administration of medication, safeguarding vulnerable adults and fire safety training. However, a sample of records reviewed indicated that one staff was overdue refresher training with regard to manual handling.

There was a residents' directory in place that was made available to inspectors. It contained all of the information required under Schedule 3 of the regulations.

All residents had contracts of care in place which were up to date. Reviewed in November 2020.

From a review of incidents that had occurred in the centre since the last inspection, the person in charge had not notified the Chief Inspector of Social Services in line with the regulations when every adverse incident had occurred in the centre.

The provider had suitable arrangements in place for the management of complaints. An inspector reviewed the complaints log and all complaints received were recorded and followed up to the satisfaction of the complainant. As previously discussed improvements were required regarding dating and timing actions for each complaint

and this is actioned under regulation 21: Records.

Regulation 15: Staffing

The provider had not obtained all of the required Schedule 2 documentation for staff files. There was a gap observed by an inspector on the roster for one required sleepover shift for the week after the inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

While staff were provided with a number of training opportunities to enable them to safely perform their roles and responsibilities, records reviewed indicated that a one staff was overdue refresher training with regard to manual handling.

Judgment: Substantially compliant

Regulation 19: Directory of residents

There was a residents' directory in place that was made available to inspectors. It contained all of the information required under Schedule 3 of the regulations.

Judgment: Compliant

Regulation 21: Records

From a review of records within the centre there were improvements required to residents' files to ensure the most up-to-date accurate information was easily accessible and that residents' plans contained all information applicable to guide staff on how best to support them.

Improvement was required in the recording of complaint forms to ensure actions were closed off appropriately and within reasonable time frames.

Judgment: Not compliant

Regulation 23: Governance and management

It was not demonstrated that oversight arrangements in the centre were effective in providing a quality, safe service to residents.

The provider had not obtained all of the information required in relation to staff specified in Schedule 2 of the regulations. The majority of written policies and procedures that guide staff practice in the centre were out of date. Residents' positive behaviour support plans were not all in date this would mean that staff may not have the most up-to-date guidance in order to support the residents. Fire containment for the hot press would not adequately protect residents in the event of a fire. Residents' files were not maintained in a manner for staff to adequately support the residents and up-to-date information was not always easily accessible. The person in charge had not always ensured that staff had access to refresher training. Not all actions identified in the centre's audits and compliance plan had been addressed or addressed in full by the time of the inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

From a review of incidents that had occurred in the centre since the last inspection, the person in charge had not notified the Chief Inspector of Social Services in line with the regulations when every adverse incident had occurred in the centre.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had suitable arrangements in place for the management of complaints. An inspector reviewed the complaints log and all complaints received were recorded and followed up to the satisfaction of the complainant.

Judgment: Compliant

Regulation 4: Written policies and procedures

While the provider did have all the required Schedule 5 policies and procedures in

place and they were available at the centre, they had not been reviewed at intervals not exceeding 3 years. Additionally food safety was not included in any policies as prescribed by Schedule 5 of the regulations

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

All residents had contracts of care in place and up to date. Reviewed in November 2020.

Judgment: Compliant

Quality and safety

Overall, residents were facilitated to enjoy a good quality of life in the centre. There were some improvements required in relation to healthcare, positive behavioural supports, protection against infection and fire precautions.

While each resident had their needs assessed on an annual basis or sooner if required in line with their changing needs and circumstances, some aspects were non-specific and did not refer to all assessed needs. These included behavioural support needs and assessment of activities of daily living. In the case of one resident this did not refer to assessed needs in relation to a particular healthcare support need. The person in charge did not ensure one resident's care plan was reviewed in light of receiving an allied healthcare professional review. This could result in staff not having all required information needed in order to fully support residents.

Residents had regular and timely access to a range of allied health care professionals as required. This included access to neurology, psychiatry, physiotherapy, occupational therapy (O.T), general practitioner (G.P), and speech and language therapy (SALT). One resident's file however did not demonstrate if recommendations from a healthcare clinic were being followed through on regularly within the centre. The last documented evidence on file was from several months ago for one of the recommendations. It was also not evident from documentation and communication with the resident if another recommendation for a particular diet plan for them was being followed through on consistently and supported as appropriate. This could mean that the resident's healthcare needs were not being followed through on as required and could impact on the resident's health as a result.

Inspectors reviewed the arrangement in place to support residents' positive

behaviour support needs. Residents were being supported to manage their behaviour positively with access to psychologists as needed and there were positive behaviour support plans in place as required. However, some plans had not been reviewed since November 2019 and another plan was last updated for a resident prior to their move to the centre. This was despite the fact that there were incompatibility issues among residents leading to incidents in the centre. Not all plans contained the most up-to-date pertinent information and were not specific in relation to restrictive practices to be used for residents in order to guide staff as to how best to support them.

There were some restrictive practices in place and they were assessed as clinically necessary for a resident's safety and wellbeing. For example, a locked food press and the use of specific medication to support residents with their anxiety. An inspector reviewed the restrictive practice log and saw evidence that restrictive practices had been reviewed on a quarterly basis.

Inspectors looked at the safeguarding arrangements in the centre and found that they were up to date and sufficient. There was a financial safeguarding plan in place for a resident and a consent form with regard to this was in place.

Residents' rights were promoted within the centre such as choosing how their bedrooms are decorated and weekly menu planning. Staff supported residents to participate in the running of their home for example a resident was observed being verbally supported to empty the house bins. Residents were encouraged to be more independent regarding self-care with staff verbally guiding residents around steps involved in preparing to shower. Residents had access to the National Advocacy Service and there was evidence of consultation with them.

Inspectors reviewed a transition plan for a resident who had moved into the centre in 2020. The resident had been consulted regarding the move to this centre. The plan was in an easy-read-format and it was signed by the resident. There were initial plans in place to progress an alternative living arrangement for another resident currently living in this centre as referred to previously.

From a walkabout of the centre inspectors found it to be spacious and homely. There were however some areas that required attention, such as decorating and repair works as some walls needed painting, some blind cords needed repair, the rubber seals around some windows were broken, there was a broken architrave around the doorway of a resident's toilet, the sink was coming away from the wall slightly in two toilets, there was a broken towel rail in an en-suite and also in that bathroom the washer in the tap needed repair as the tap was dripping. One resident's ceiling had a small mark from a leak. Centre management and staff communicated that they had not been aware of this so it was not clear to an inspector if this was a current leak or a mark from an old leak that had yet to be repainted. At the side of the house some of the concrete surface was cracked and the bottom of the shed door was rotten. As previously mentioned the back garden paving was uneven, the shed needed some repair and the picnic table needed to be painted.

There were risk management arrangements in place, including a risk management policy and procedures. The centre had a risk register and a health and safety statement in place. All risks identified on the risk register had an individual risk assessment. There were individual risk assessments in place for each resident in order to support their safety and wellbeing. However, as previously mentioned some improvements were required to risk management in the centre. The risk management policy needed review in order to explain measures/actions in place to control certain risks as described in the regulations. One resident's risk assessment needed revision to include the wider implications of a specific risk. One resident's care plan advised for a prescribed powder to be locked away and inspectors observed it was not locked away. This powder has the potential to be a choking hazzard. There was a contents sheet for all residents' individual risk assessment folders but the dates of when reviewed on this page did not always match the dates on the assessments themselves. Therefore it was difficult to know if the risk assessments in place were the most up-to-date assessments.

The provider had systems in place for the prevention and management of risks associated with COVID-19. Staff had been provided with training in infection prevention and control, and hand washing techniques however, as previously stated a number of staff were overdue refresher courses. PPE was available in the centre and staff were observed using it in line with national guidelines. For example, masks were worn by staff at times when social distancing was not possible to maintain in the centre. There was adequate hand-washing facilities and hand sanitising gels available throughout the centre. Enhanced cleaning schedules had been implemented however the cleaning checklist had some gaps in the recording of the documentation. There were slight patches of mould around one resident's window seal and on the window itself and again in another resident's bathroom on the shower door and some areas of grouting around shower tray.

Inspectors observed that there were colour coded cloths for cleaning the centre. There were also colour coded mops and buckets however, the mops were inappropriately stored sitting on the buckets which would not promote adequate drying of the mop heads. The centre had colour coded chopping boards in place however, there was no chopping board for cooked meats.

The provider did not make the centre's full COVID-19 contingency plan available to inspectors other than a specific guidance piece on what to do in the event of a resident having a suspected or confirmed case. This did guide staff as to what to do it in this event but it was last reviewed in June 2020. The person in charged had completed a COVID-19 self-assessment tool and it had recently been reviewed and there was an identified COVID-19 lead in place. There was up-to-date HSE guidance in relation to COVID-19 in a dedicated folder.

A review of the fire precaution arrangements for the centre showed that while there were fire safety management systems in place improvement was required. For example, as previously mentioned with regard to the hot press fire door not having an intumescent strip or cold smoke seal in order to resist the passage of fire and smoke in the event of a fire.

One resident's up-to-date personal emergency evacuation plan (peep) was not made available to inspectors in order to ascertain if it had been updated in line with a resident's recent refusal to leave in the event of a fire. The peep available did not make reference to refusals and therefore did not guide staff of what to do in the event of an emergency if this were to happen. Examples of sufficient fire safety arrangements in the centre included emergency lighting and signage, servicing of firefighting equipment, fire drills were regularly completed using different scenarios and staff were trained in fire safety. There was a pictorial of the list and locations of firefighting equipment in the centre and there was an easy-to-read fire evacuation on display which contained pictures. A resident spoken with was able to talk an inspector through what to do in the event of a fire.

Regulation 17: Premises

Some improvement was required to the decor of the premises and some facilities were in need of repair.

Judgment: Substantially compliant

Regulation 25: Temporary absence, transition and discharge of residents

It was found that in the case of the most recent admission to the centre the resident was consulted and the plan was in an easy-read-format and it was signed by the resident. There were initial plans in place to progress an alternative living arrangement for another resident currently living in this centre.

Judgment: Compliant

Regulation 26: Risk management procedures

The risk management policy needed review in order to explain measures/actions in place to control certain risks as described in the regulations. One resident's risk assessment needed revision to include the wider implications of a specific risk. One resident's care plan advised for a prescribed powder to be locked away and inspectors observed it was not locked away. This powder has the potential to be a choking hazzard. There was a contents sheet for all residents' individual risk assessment folders but the dates of when reviewed on this page did not always match the dates on the assessments themselves. Therefore it was difficult to know if the risk assessments in place were the most up-to-date assessments.

Judgment: Substantially compliant

Regulation 27: Protection against infection

There were improvements required such as mop heads were store inappropriately, gaps in cleaning schedule, slight mould in some areas of the house, the main COVID-19 contingency plan was not made available and the last review of the specific guidance to staff on what to do in the case of a suspected or confirmed case had not been reviewed since June 2020

Judgment: Substantially compliant

Regulation 28: Fire precautions

The hot press fire door did not have an intumescent strip or cold smoke seal in order to resist the passage of fire and smoke in the event of a fire. One resident's up-to-date personal emergency evacuation plan (peep) was not made available to inspectors in order to ascertain if it had been updated in line with a resident's recent refusal to leave in the event of a fire. The peep available did not make reference to refusals and therefore did not guide staff of what to do in the event of an emergency if this were to happen.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Some aspects of individual assessments were non-specific and did not refer to all assessed needs such as behavioural support needs and assessment of activities of daily living. One resident's plan did not refer to assessed needs in relation to a particular healthcare support need. The person in charge did not ensure one resident's care plan was reviewed in light of receiving an allied healthcare professional review.

Judgment: Substantially compliant

Regulation 6: Health care

One resident's file did not demonstrate if recommendations from a healthcare clinic

were being followed through on regularly within the centre. It was also not evident if another recommendation for a particular diet plan for them was being followed through on consistently and supported as appropriate.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Positive behaviour support plans in place required review as some had not been reviewed since November 2019 and another had not been reviewed since a resident moved to the centre despite compatibility issues within the centre. Not all plans contained the most up-to-date pertinent information and were not specific in relation to restrictive practices to be used for residents.

Judgment: Not compliant

Regulation 8: Protection

There were arrangements in place to protect residents from the risk of abuse.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported to participate in the running of the centre and to exercise choice in their lives.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Coolamber House OSV-0001836

Inspection ID: MON-0029061

Date of inspection: 07/10/2021

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: The roster for the shifts identified by the inspector on the day of inspection were reviewed and corrected this was completed 7/10/21. The Human Resources Dept has liaised with the staff in question regarding the gap in her CV as identified by the inspector and the staff member has corrected this gap with the appropriate information to HR, completed 12/11/21. The Human Resources Dept has issued a letter confirming the number of contractual hours for one staff member this was issued on the 8/11/21. The employee identified in the report needing a reference from a previous employer has contacted previous employer head office re this 30/11/21 and will furnish this reference to HR 6/12/21.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Manual handling refresher training identified for one staff member took place 25/11/21. Training for two staff members specific to one individual resident in the centre will take place on the 16/12/21. A new staff training matrix has been introduced to this centre to ensure that all refresher training is scheduled and timely, this training schedule is on display in the centre 8/11/21. It is the practice of St. Hilda's Services to allow all new staff to familiarise themselves with the process and business of a centre before they attend training. Epilepsy training does not commence until Medication training is completed. The new employee in question has completed practical assessments for Medication Management on the 12/11/21 which is within the schedule for such training.	

The new employee does not work alone with the resident who has epilepsy prior to training. The new employee completed epilepsy training on the 15/11/21.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records: A meeting took place on the 8/11/21 which was attended by all PICs, Residential Services Manager, Operations Manager and the recently appointed Compliance Manager to review all schedule 3 documentation and to stream - line the content and make the file more user friendly going forward. The new streamlined version of the schedule 3 file has been distributed to centres for commencement of use. The Compliance Manager Will Audit all documents for content, date and signature on a weekly basis for centres who have non-compliance and monthly alongside a HSE Quality Manager when they are satisfied that all records are compliant with HIQA Regulations. The inspection will commence week of 17/11/21 until the centre comes into compliance. The Residential Services Manager will schedule three Bi-weekly meetings in the short term with the Person in Charge to discuss and update any issues regarding documentation such as individual plans, BSP Plans and safeguarding in the centre and to highlight any learning from this process. these meetings will commence from 6/12/21 and thereafter will be subject to review with the PIC at regular six-monthly supervision meetings. All complaints in the centre have been reviewed and closed off by the PIC 11/11/21.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: The Human Resources Dept has liaised with the staff in question regarding the gap in her CV as identified by the inspector and the staff member has corrected this gap with the appropriate information 12/11/21. The Human Resources Dept has issued a letter regarding the number of contractual hours for one staff member this was issued on the 8/11/21. The employee identified in the report needing a reference from a previous employer has contacted previous employer head office re this 30/11/21. The current policy review sheet outlines the policy schedule review for the service. Five schedule 5 policies have been reviewed and issued 8/11/21, while a further 3 were approved by the board and distributed 16/11/21 with the remainder currently under review for board approval Quarter 4 2021 and Quarter 1 2022. Food safety is included in the services Nutrition Policy page 9 which has been reviewed and distributed 8/11/21. All Behaviour Support Plans have been reviewed and up dated accordingly. Resident 1 Plan

is in place and was updated and signed by the psychologist 20/5/21.

Resident 2 Plan was reviewed, updated and signed by a behavioral specialist 11/11/21.

An interim plan has been put in place for Resident 3, this plan is only in place until the process of developing a new plan is completed with the psychologist. A copy of same has gone to the psychologist 13/11/21 and is currently under review.

The process to date is as follows, a number of meetings with the psychologist has been agreed, a meeting was held with the psychologist on 10th November. Further meetings will happen every Monday starting 22nd November where the psychologist will meet with Operations Manager, PIC and key worker staff. At the end of this process a detailed behaviour support plan will be agreed and in place for Resident 3. The following has been put in place as part of the process of developing a plan.

A Frequency of incident chart has been put in place.
A weekly timetable, scheduled by the hour has been put in place.
An additional incident recording sheet from the psychologist has been added.
Weekly visits to home (3 times per week) has been put in place.
Jobs have been secured for Resident 3 and this is working well.
Additional staffing for evenings and weekends was allocated by the provider 2 months ago so that Resident 3 has a day and evening individualised staff and programme and these interventions and supports are also being reviewed.

The hot press fire door has had an intumescent strip fitted, this was completed 8/10/21.

A meeting took place on the 8/11/21 which was attended by all PICs, Residential Services Manager, Operations Manager and the recently appointed Compliance Manager to review all schedule 3 documentation and to stream - line the content and make the file more user friendly going forward. The new streamlined version of the schedule 3 file has been distributed to centres for commencement of use. The Compliance Manager Will Audit all documents for content, date and signature on a weekly basis for centres who have non-compliance and monthly alongside a HSE Quality Manager when they are satisfied that all records are compliant with HIQA Regulations. The inspection will commence week of 17/11/21 until the centre comes into compliance. The Residential Services Manager will schedule three Bi-weekly meetings in the short term with the Person in Charge to discuss and update any issues regarding documentation such as individual plans, BSP Plans and safeguarding in the centre and to highlight any learning from this process. these meetings will commence from 6/12/21 and thereafter will be subject to review with the PIC at regular six-monthly supervision meetings. All complaints in the centre have been reviewed and closed off by the PIC 11/11/21..

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Designated Officer, Residential Services Manager has had a formal meeting with the Person in Charge outlining her responsibility to notify all adverse incidences in the centre to the Authority in line with Regulation 31 completed 9/11/21. Going forward the Person in Charge will review in consultation with the Designated Officer all safeguarding incidences that occur in the centre and notify accordingly. The Residential Services Manager will schedule regular Bi-weekly meetings with the Person in Charge and the staff on duty to discuss and update any issues regarding documentation such as individual plans, BSP Plans and safeguarding in the centre and to highlight any learning from process or audits of the centre, these meetings will commence from 22/11/21. The provider is satisfied that the Person in Charge is clear on their obligation and that the Designated officers will support this.

Regulation 4: Written policies and procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The current policy review sheet outlines the policy schedule review for the service. Five schedule 5 policies have been reviewed and issued 8/11/21, while 3 have been approved by the board and distributed 16/11/21 with the remainder currently under review for board approval quarter 4 2021 and quarter 1 2022. Food safety is included in the services Nutrition Policy Page 9 which has been reviewed and distributed 8/11/21. All updated policies can be viewed on site in the centre.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The mould issue in relation to the shower door, Shower tray and residents window was treated 18/11/21 The rubber seals around the windows was repaired 18/12/21 The fence has been cleaned and the shed door will be repaired 19/11/21. The picnic table will be repainted and both sinks repaired 19/11/21. The uneven surface at the side of the property has been repaired 16/11/21 The painting has been completed 16/11/21.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Risk Management Policy has been updated and revised to include measures/actions in place to control risks as outlined in regulation 26 (i)(ii)(iii)(iv), This was completed 10/11/21 and was approved by the Board on the 16/11/21and distributed. The risk assessment in relation to the powder as identified by the inspector has been reviewed and revised to ensure that this risk of a potential choking hazard is eliminated and all staff have been reminded of the importance of safe storage of same 12/11/21. The contents sheet for resident's individual risk assessments has been revised to reflect full review dates of all assessments completed 10/11/21.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The Covid Lead Worker Representative visited the centre on the 5/11/21 and has reviewed all cleaning Schedules and has issued new cleaning schedules for daily, weekly and monthly cleaning checks which were issued on the 20/10/21 and 5/11/21. Instructions in relation to the monitoring and completion of said schedules by all staff members has been outlined by the Covid Lead Worker Representative. The Covid Lead Worker Representative has also instructed all staff members on the proper storage of mops in the storage press. Hooks for mops were installed and completed on 8/11/21. A sight specific Covid Response Plan has been issued to the centre 18/10/21. The mould issue in relation to the shower door, Shower tray and residents window was treated 18/11/21. A new chopping board specifically for cooked meats has been purchased 12/11/21.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The hot press fire door has had an intumescent strip fitted, this was completed 8/10/21. The PEEP for one resident outlining the resident's refusal to leave in the event of a fire has been revised and updated to guide staff of what to do in the event of an emergency if this were to happen, Completed 5/11/21.

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:
Individual Needs Assessments for all residents have been reviewed by the Person in Charge to ensure that all needs are specific to the individual and all have been updated this was completed on the 6/11/21. The Care Plan for one resident has been updated to reflect allied Health care professional review 6/11/21.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The Annual Health Check for one Resident was completed on the 11/11/21 and care plans were subsequently updated to reflect this.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
All Behaviour Support Plans have been reviewed and up dated accordingly.

Resident 1 Plan was in place and was updated and signed by the psychologist 20/5/21.

Resident 2 Plan was reviewed, updated and signed by a behavioral specialist 11/11/21.

An interim plan has been put in place for Resident 3, this plan is only in place until the process of developing a new plan is completed with the psychologist. A copy of same has gone to the psychologist 13/11/21 and is awaiting a response.

The process to date is as follows, a number of meetings with the psychologist has been agreed, a meeting was held on 10th November 21. Further meetings will happen every

Monday starting 22nd November where the psychologist will meet with Operations Manager, PIC and key worker staff. At the end of this process a detailed Behaviour Support Plan will be agreed and in place for Resident 3. The following has been put in place as part of the process of developing a plan.

A Frequency of incident chart has been put in place.
A weekly timetable, scheduled by the hour has been put in place.
An additional incident recording sheet from the psychologist has been added.
Weekly visits to home (3 times per week) has been put in place.
Jobs have been secured for Resident 3 and this is working well.
Additional staffing for evenings and weekends was allocated by the provider 2 months ago so that Resident 3 has a day and evening individualised staff and programme and these interventions and supports are also being reviewed.

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 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	07/10/2021
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	06/12/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	16/12/2021

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	16/11/2021
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	19/11/2021
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	22/11/2021
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	11/11/2021
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	Not Compliant	Orange	22/11/2021

	to residents' needs, consistent and effectively monitored.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	31/01/2022
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: accidental injury to residents, visitors or staff.	Substantially Compliant	Yellow	16/11/2021
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	Substantially Compliant	Yellow	10/11/2021

	risk, including a system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	18/11/2021
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	08/10/2021
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	05/11/2021
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse	Not Compliant	Orange	21/11/2021

	incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
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	16/11/2021
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.	Not Compliant	Orange	16/11/2021
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 as required to reflect changes in need and circumstances, but no less frequently	Substantially Compliant	Yellow	06/11/2021

	than on an annual basis.			
Regulation 05(6)(d)	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 take into account changes in circumstances and new developments.	Substantially Compliant	Yellow	06/11/2021
Regulation 06(2)(b)	The person in charge shall ensure that where medical treatment is recommended and agreed by the resident, such treatment is facilitated.	Substantially Compliant	Yellow	11/11/2021
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	Orange	13/11/2021