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:	National Association of Housing for Visually Impaired
Name of provider:	National Association of Housing for Visually Impaired CLG
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	01 April 2022
Centre ID:	OSV-0001938
Fieldwork ID:	MON-0035907

About the designated centre

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

This is a residential service for four adults with visual impairment and additional needs. The centre can cater for 16 residents over the age of 18 years, male and female. The centre is staffed with two social care workers, and 20 care assistants along with the person in charge and service manager. The centre comprises of four houses which are close to local amenities such as shops, train stations, bus routes and churches. Day services are not provided. Residential care is provided across 24 hours with sleep over staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 1 April 2022	10:30hrs to 16:00hrs	Sarah Cronin	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out to assess the arrangements in place concerning infection prevention and control measures and to monitor compliance Regulation 27: Protection against infection and the associated National Standards for Infection Prevention and Control in Community Services (HIQA, 2018). The inspector found this to be a person - centred service which provided good quality support to the residents. While the inspector found good infection prevention and control practices to be in place, some improvements were required to ensure that the standards were being met.

This centre provides a service to 16 adults who have a visual impairment and additional support needs. The centre comprises four houses. Two of these houses are adjoining and share a back garden in which there were two garden rooms that serve as a PPE store and donning and doffing station and an office for the person in charge. Each of these houses have four bedrooms with one of these bedrooms being en suite, a kitchen/ dining area, a utility room, staff office, bathroom, toilet, a dining room and a sitting room. The other two houses are also adjoined with a shared back garden in a nearby estate. These houses had four bedroom with two of these being en suite in each house. In the fourth house, an additional bedroom was made downstairs to cater for a resident requiring ground floor accommodation. This set of houses also had a garden room to the rear which was used as a PPE store and a donning and doffing station where required.

The inspector spoke with eight residents, three staff members and the person in charge during the inspection. The inspector spent time visiting each property, observing the physical environment and reviewing documentation. In addition to speaking with residents and staff, the inspector observed residents' daily interactions and routines. On arrival to the first house, the inspector was greeted at the door by a resident and a member of staff and taken to the back of the house to meet the person in charge. In line with new guidance issued, the staff member did not request for the inspector to take their temperature. However, there was evidence to show that this had been standard practice in place prior to this. There was a visitors checklist in place to manage the risk associated with visitors in the centre. There was hand gel available at entrances and exits to the house.

It was evident to the inspector that the provider was engaging and supporting residents with understanding restrictions and/or the need to isolate in addition to learning standard precautions such as hand hygiene and wearing masks. Residents spoke with the inspector about the first set of restrictions due to the COVID-19 pandemic and how they were affected. There had been one outbreak of COVID-19 in the centre. One of the houses closed at this time and residents went home to their families. Residents affected were supported to self-isolate as much as possible in that time.

On speaking with the residents, those who communicated verbally indicated that

they were aware of the rationale for having their temperatures checked twice a day and the need to wear masks in public places. Information had been made available to residents in Braille about understanding the need for restrictions, rules about isolation and the vaccine. Residents told the inspector how they had been supported to get their vaccines for COVID-19 and for the flu. Staff had worked with residents to seek consent had documented a decision making agreement with each resident on their wishes about the vaccine and about being tested for COVID-19. As part of the annual review for 2020, the provider had undertaken a consultation exercise with residents to determine what their views were on the support they had received during the pandemic. This report was not available for the inspector to view on the day of the inspection.

Residents told the inspector about their preferred activities and about their daily routines. The residents led active lives in the community and did a number of different activities including going to college in the city, online zoom classes, going for long walks and attending day services. Staff supported residents at least once a week with a practical demonstration and assessment of residents carrying out hand hygiene.Some of the residents had been supported to use public transport independently and were aware of the need to wear a mask. Some of the residents spoke about enjoying doing their preferred activities again such as going out for a meal or for coffee. One of the residents played piano for a local nursing home and another went into the city to attend college. Both residents reported to be happy to be back doing these activities again.

The inspector found that overall, the centre was operating at a good standard of infection prevention and control practice and that the provider was ensuring that residents were appropriately protected from health care -associated infections. The next two sections of the report will outline the findings in relation to governance and management and how these arrangements impacted on the quality and safety of infection prevention and control. The findings will be presented under Capacity and Capability and Quality and Safety and an overall judgment on compliance with regulation 27.

Capacity and capability

Overall, the inspector found that the provider had implemented good systems and arrangements to ensure that their procedures were in line with the National Standards for Infection Prevention and Control in Community Services (HIQA, 2018). There were clear governance and management structures in place to minimise risks to residents of acquiring or transmitting preventable health care- associated infections. The provider had a contingency planning meeting every two weeks. This group was made up of senior managers and chaired by director of operations. In addition to this forum, there was a central crisis management intervention team to provide support and guidance to services. Within the centre, two of the social care workers were identified as 'Covid Leads'. The organisation had access to and

interacted with the HSE Public Health as they required it. However, it was unclear who was providing specific IPC expertise and advice within the organisation. The person in charge was knowledgeable about the use of antibiotics and gave the inspector examples of managing this for residents on an individual basis with the local GP. However, it was not clear what arrangements the provider had in place to ensure oversight of antimicrobial stewardship. Infection Prevention and Control was considered in the provider's annual review and six monthly review of the quality and safety of the service.

The provider had an infection prevention and control policy in place and guidance for staff on managing outbreaks of infection, the safe use and management of sharps, hand hygiene guidance, the management of laundry and linen and the management of soiled/contaminated laundry. However, some of the guidance required further clarity to ensure all staff consistently managed cleaning and disinfection in the same way and that staff were able to safely manage clinical waste, soiled laundry and any spillage of body fluids.

Oversight of the practices in the centre were achieved through weekly audits in infection prevention and control. These were carried out by shift leaders on a weekly basis with the staff member on duty to ensure all staff had the opportunity to engage in the audit process. The provider had good systems of environmental audit and oversight of identified issues with maintenance. A clear maintenance log was kept with items risk rated in order to prioritise works required. On inspection of each of the house, the inspector noted that the person in charge had identified all of the areas observed which required improvement.

The provider had an appropriate number of staff in place for each house who had the required skills to provide support to resident including meeting the services infection prevention and control needs and activities. There were emergency governance arrangements in place and contingency planning to ensure that staffing levels remained at the required quota to meet residents' assessed needs. Individual contingency plans were in place for residents based on their support needs and ability to self-isolate and family arrangements in the event the resident wished to stay with family. On the day of the inspection, there was a reduced staff ratio in two of the houses due to a positive case of COVID-19. This had an impact on residents' ability to engage in activities outside the house. Later in the afternoon, two of the staff took all of the residents out for a walk. Staff were noted to practice hand hygiene in line with guidance and there were adequate facilities to wash and sanitise hands in each house.

Staff had completed a number of training courses relating to infection prevention and control. The provider had devised their own e-learning programme on infection prevention and control. In addition to completing this course, staff had completed training in basic infection prevention and control measures, donning and doffing personal protective equipment (PPE), respiratory hygiene and cough etiquette and on hand hygiene. However, staff had not received any training on cleaning and disinfection, management of spills and there was a lack of clarity between staff on appropriate management of soiled/ contaminated laundry. Staff had access to up to date information and guidance on COVID-19 and other health care acquired

infections such as Clostridium Difficile, MRSA and Norovirus.

Staff meetings took place every fortnight. Minutes viewed by the inspector did not indicate discussions about infection prevention and control were taking place or that learning from the outbreak which had occured was reflected upon.The provider had issued a newly updated protocol for IPC the day prior to the inspection which was in the process of being circulated to staff.

Quality and safety

The inspector found that the services in the centre were person-centred and that the provider was engaging and supporting residents with understanding restrictions and/or the need to isolate in addition to learning standard precautions such as hand hygiene and wearing masks. Residents spoke with the inspector about the first set of restrictions due to the COVID-19 pandemic and how they were affected. They were aware of the rationale for having their temperatures checked twice a day and the need to wear masks in public places. Information had been made available to residents in Braille. As part of the annual review for 2020, the provider had undertaken a consultation exercise with residents to determine what their views were on the support they had received during the pandemic. This report was not available for the inspector to view. Residents told the inspector how they had been supported to get their vaccines for COVID-19 and for the flu. There was evidence that the provider had engaged with residents to seek consent and a decision making agreement with each resident on their wishes about the vaccine and about being tested for COVID-19 was documented in their care plans.

The inspector noted that all staff in the houses were wearing surgical masks, which was contrary to guidance from the Health Protection and Surveillance Centre (HPSC) and the provider's updated internal guidance to staff. Staff were aware of standard and transmission-based precautions and were able to describe these to the inspector. There was a garden room out the back of each house which was used as a donning and doffing station in the event that this was required. Staff were observed to practice hand hygiene throughout the day and there was an adequate number of hand gels easily accessible. It was noted that in general areas of the centre such as the kitchen, open bins were used. This had been identified and risk assessed in order to maintain residents' independence in light of their needs. All other bins in the houses were noted to be pedal operated. There was signage throughout the centre including signage in Braille. There was appropriate systems in place for the management of domestic waste. Clinical waste was not regularly produced but it was unclear what protocol was in place in the event this was required. For example the policy instructed staff to double bag but to seek further advice from a GP, HPSC or health care provider to dispose of the waste.

The centre was noted to be clean and for the most part in a good state of repair. Equipment was found to be mostly clean. However, shower chairs were found to be

rusted in two of the bathrooms. Where repairs were required, these had been self-identified and a clear log of all reported maintenance issues was kept and risk rated to ensure necessary works were completed in a timely manner. As stated above, there was no policy, guidance or training for staff on cleaning and disinfection where there was an outbreak of infection in the centre. Staff spoke about the day - to - day cleaning practices, weekly cleaning and cleaning of touch points. There were cleaning schedules kept in each of the houses and high touch areas were cleaned six times daily. There were colour coded mops and colour coded chopping boards in place. This helped staff to identify which equipment should be used when completing tasks in different areas to minimise the risk of the transmission of potential infections.The provider had advised staff to use disinfectant wipes rather than cloths and these were disposed of after each use. Staff were unclear on cleaning and disinfecting mops after each use. Additionally, they were not instructed on the exact products to use in the event of an outbreak of any health care associated infection. The inspector was not assured that staff were suitably equipped to ensure the houses were cleaned and disinfected adequately in the event another outbreak occured.

Laundry management also required improvement. While each resident had a set day to do their laundry and staff wore appropriate PPE when handling linen, staff were unclear how they would manage contaminated laundry. Staff were not able to clearly describe how to manage spillage of body fluids safely and they did not have access to spill kits. There was one sharps box in use for a resident in the centre. This was stored in the resident's bedroom in a locked cabinet. The resident disposed of their own sharps after each use. The sharps box was noted to have no label on it and was not closed properly. The resident told the inspector how the sharps bin was disposed of in a local health centre.

Staff were monitored three times daily in addition to residents for symptoms. Staff were required to sign a self-assessment form and a hand hygiene audit at the beginning of each shift. The provider had completed the Health Information and Quality Authority (HIQA) preparedness and contingency planning and self-assessment for COVID-19 tool. This was to ensure that appropriate systems, processes, behaviours and referral pathways were in place to support residents and staff to manage the service in the event of an outbreak of COVID-19. Outbreak contingency management plans were in place which had specific information about the roles and responsibilities of the various roles within the organisation which had an escalation procedure and protocols in place to guide staff on managing an outbreak in the centre. However, there was not evidence of learning or reviewing the outbreak which had occured.The provider did have a template for an outbreak report but this had not been completed in relation to the outbreak in the centre.

Regulation 27: Protection against infection

The provider was found to be generally meeting the requirements of Regulation 27 and the National Standards for Infection Prevention and Control in Community

Services. The inspector found that the provider had developed a number of effective systems and processes for the oversight of review in infection prevention and control practices in the centre. There was evidence of good practice in relation to engaging with and supporting residents and in hand hygiene. However, some areas as noted in the body of the report, required improvement. These included the following:

- There was a lack of clarity over who was providing expert advice and guidance in infection prevention and control within the organisation.
- There was not a clear governance structure or procedures in place at provider level on antimicrobial stewardship. Staff had not received training on antimicrobial stewardship.
- Policies and procedures did not guide practices in detail on:
    - Cleaning and disinfection of household areas and equipment. This included the need for clarity on the cleaning methods and products to be used in the event of an outbreak and cleaning equipment used for cleaning.
    - Disposal of clinical waste where required.
    - The management of body fluids.
    - The management of contaminated laundry.
- Staff were not wearing appropriate PPE in line with current guidance.
- There was not evidence of learning from the outbreak which had occured.
- Information sharing with staff also required improvement - staff meetings did not regularly discuss infection prevention and control.
- The management of sharps required improvement to reduce the risk of a sharps injury. The lid of the box was open and the box was not labelled.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Quality and safety	
Regulation 27: Protection against infection	Substantially compliant

Compliance Plan for National Association of Housing for Visually Impaired OSV-0001938

Inspection ID: MON-0035907

Date of inspection: 01/04/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 27: Protection against infection	Substantially Compliant

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

Action 1: Staff were immediately advised by the Service Manager to wear FFP2 masks as per current guidance. Service Manager will discuss this at next team meetings. Service Manager by 30.04.22. This action has been completed.

Action 2: Learning review to be completed regarding Covid-19 outbreak. Service Manager by 30.04.22. This action has been completed.

Action 3: Standing item on infection prevention and control to be included on all team meeting agendas going forward. Service Manager immediate action. This action has been completed.

Action 4: Specific review of short- term medication, including antibiotics, will be added to the monthly medication audit tool. The SM has governance oversight of this and will therefore be able to identify any patterns or trends which may suggest inappropriate usage of antibiotics which will then be escalated to the relevant medical professional, i.e. the prescriber. This will be in place from 27 May 2022.

Action 5: The Organisation receives all updates re IP&C from relevant professional bodies, e.g. HSE, Public Health, etc. These are then disseminated to SMs by the Senior Management Team including the Operations Director as appropriate, with relevant updates to Policy and Procedure. The Operations Director is a Registered General Nurse with a Masters in Nursing and therefore has the relevant expertise in IP&C. Action Completed.

Action 6: Team Meeting to include agenda addressing managing outbreaks of infection, the safe use and management of sharps, the management of laundry and linen and the management of soiled/contaminated laundry to ensure staff have clarity on each.

Completion by 3 June 2022.

Action 7: SM to review with staff at Team Meting the cleaning products used on a daily basis as well as the cleaning products required during potential outbreaks to ensure clarity with all staff. To be completed by 3 June 2022.

Action 8: Confirm with Health Centre that the sharps box is appropraitely labelled. This action has been completed. The Health Centre confirmed that the sharps box was appropriately labelled.

Action 9: Staff to confirm with the person we support, who manages her own sharps box, how to ensure that the lid is placed appropriately at all times. This action has been completed.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 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	03/06/2022