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:	Abode Doorway to Life CLG
Name of provider:	Abode Doorway to Life CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	10 March 2022 and 11 March 2022
Centre ID:	OSV-0002411
Fieldwork ID:	MON-0036390

About the designated centre

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

The designated centre provides residential and respite services for up to 10 adults with physical and sensory disabilities on the outskirts of Cork City. The designated centre is a purpose built building, which comprises of residential units and communal areas for residents. The service operates 24 hours a day, 7 days a week all year round. Staff sleep over in the accommodation provided and are on call for emergencies. The staff team comprises of social care and nursing staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	8

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 10 March 2022	10:30hrs to 18:35hrs	Caitriona Twomey	Lead
Friday 11 March 2022	11:00hrs to 16:30hrs	Caitriona Twomey	Lead
Thursday 10 March 2022	10:30hrs to 19:30hrs	Lucia Power	Support
Friday 11 March 2022	11:45hrs to 16:30hrs	Lucia Power	Support
Thursday 10 March 2022	13:00hrs to 19:30hrs	Michael O'Sullivan	Support

What residents told us and what inspectors observed

This was a risk-based, unannounced inspection. This inspection was planned following the receipt of information regarding the centre. Two urgent actions were issued on the first day of this inspection. One related to the governance and management arrangements, the other to fire precautions in the centre. Given the seriousness of the findings in all regulations inspected, members of the governing board were asked to meet with the inspectors and to attend the feedback session at the close of this inspection. Members of the board and management team present during the inspection expressed a commitment to address the identified non compliances with the regulations.

The inspection took place over two days in March 2022. Three inspectors participated in the first day of the inspection, with two of these completing the inspection on the following day. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspectors and all staff adhered to these throughout the inspection.

On arrival, the inspectors met with two members of the management team. One of these had been appointed to the role on an interim basis earlier that week. Prior to that, they had never worked in the designated centre. The Health Information and Quality Authority (HIQA) had been informed that the most recent person in charge of the centre had left the role on 09 February 2022. It was confirmed that no person in charge had been appointed to this vacancy. The person, as notified to HIQA, who was to fulfil the responsibilities in the absence of the person in charge was also on extended leave. Prior to this inspection, HIQA had last inspected the centre in September 2021. At that time there was also no person in charge appointed. In the course of this inspection, it was identified that other key roles were either vacant or were filled on a part-time basis. This resulted in gaps in the governance and management of specific areas of care and support provided in the centre. An urgent action was issued requesting that the governance and management arrangements in the centre be clarified and documented, outlining who was responsible for identified key areas and the reporting structures in place. These gaps and the impact they had on the quality of the service provided in the centre will be discussed in more detail later in this report.

The designated centre was located in a purpose built facility in a suburb of Cork city. The centre provided a residential service for a maximum of 10 people with physical and sensory disabilities. Parts of the building were not included in the designated centre. Services provided in these areas included a day service, a training service, and other accommodation where people lived as part of a tenancy arrangement. Overnight accommodation was provided over two floors in the split-level building. This design ensured that those on the first floor could access the outdoors using external doors. Each resident had their own bedroom with an ensuite bathroom. Those accessing the long-term respite service had the exclusive use of a studio apartment which included an accessible kitchen, dining and living area, bedroom

and bathroom. An inspector met two residents in their bedrooms. These had been personalised and reflected the interests and personalities of the people living there. There was a communal area on each floor of the centre. The dining room was on the ground floor and there was a common area in the landing area on the first floor with tables and chairs, and a computer for general use. Since the last inspection of this centre, this area had been renamed as a 'tea room' and had been equipped with some tea and coffee making facilities. As was highlighted in the September 2022 inspection report, residents did not have access to the main kitchen in the designated centre.

There were three different types of supported accommodation service provided to residents in the designated centre. There was a long-term residential service available to six residents, long-term respite available to two residents and a short-term respite service available to two residents at any one time. One of the current long-term residents had previously been a tenant in the same building. Since the last inspection of this centre, one long-term resident and one long-term respite resident had moved out. At the time of this inspection, there were six long-term residents, one long-term respite resident and one resident accessing short term respite in the centre. Over the two days of the inspection, inspectors spoke with a number of staff and three residents. All residents who were in the centre during the inspection were informed of the inspectors' presence and were invited to speak with them if they wished.

Residents who spoke with the inspectors were generally positive about their experiences of living in the centre. At the time they met with the inspector, one resident was watching the television in their room, another was preparing to go out independently and the third was spending time on the computer available in the common area on the first floor. One resident said they were 'happy enough' and felt safe living there. All three residents spoke very positively about the staff member who was assigned to be their key worker and the support they provided. One resident spoke about 'an issue' they had regarding the availability of transport in the service and how their key worker had helped them to resolve it. A number of residents living in the centre had jobs. Residents' independence was clearly very important to them, with one resident telling the inspector they 'do what they can' for themselves. Residents who had attended residents meetings spoke positively about the meetings. An inspector was told that these meetings were useful, informed residents about changes in the service, and covered a variety of topics. When the topic of complaints was raised, two residents said they had never made a complaint. One resident told an inspector that they had not made complaints previously when they felt they should have and had recently made a complaint. While initially they were positive when discussing this, the resident then became upset. They informed the inspector that they were now 'worried' and 'very stressed' as a result of making a complaint. They spoke about potentially accessing the support of an advocate regarding this matter. Complaints will be discussed further in the 'Capacity and capability' section of this report.

Inspectors spoke with a number of staff, employed in various positions, who were working in the centre over the two days of this inspection. Each staff member demonstrated a commitment and desire to providing a person-centred service to the

residents. All emphasised that the centre was the residents' home and spoke about how they supported them to exercise their rights within the centre. The majority of the staff spoken with had started working in the centre within the previous 18 months. Staff were very positive when speaking about the residents and the relationships they had developed with them. Staff consistently reported that there was a different atmosphere at times in the centre and it was noticeable when residents were more relaxed. As was noted when inspectors reviewed the residents' meeting minutes, staff reported that they encouraged residents to make complaints if there was anything that they were not satisfied with, or wished to change, about the service provided. Despite this encouragement, complaints were rarely made in the centre. Staff gave examples of matters that residents had raised with them and wanted addressed but went on to say that residents were either reluctant to, or would not, make a complaint. Staff spoke about one resident recently asking if they would be in trouble because they were sick and as a result would be spending more time than usual in the centre. In one documented incident it was recorded that a resident had asked if their place in the centre was at risk during an interaction initiated following the resident making a comment that could be interpreted as a complaint. Staff also reported that residents had commented to them on negative treatment received by others (both staff and other residents) in the centre.

Another consistent theme reported by staff was that they believed the centre was not sufficiently resourced. Staff reported that they were constrained in their abilities to provide a safe and high quality service due to the number of staff on the team and the staffing ratios in place, especially during the day. Two staff reported that they had recently worked for over 10 consecutive days in the centre. Staff advised that their concerns about the number of staff rostered to work in the centre at any one time had been raised with senior management but to date it had not been addressed. Although positive about the support provided from some colleagues and members of the management team, staff advised that they were not always clear on who to contact or how to access support in the absence of these staff or when they were working alone in the centre.

In the course of discussions with inspectors, it was alleged that there had been a period of time in recent weeks when there were no staff present in the designated centre when residents assessed as requiring staff support were present. This alleged safeguarding incident had not been notified to HIQA, as is required by the regulations. A notification regarding this matter was submitted before the close of the inspection.

As well as spending time with the residents in the centre and speaking with staff, the inspectors reviewed some documentation. Documents reviewed included the most recent annual review and the report written following the most recent unannounced visit to monitor the safety and quality of care and support provided in the centre. These reports will be referenced in the 'Capacity and capability' section of this report. The centre's staffing rosters and complaints log were also reviewed. Inspectors read minutes of residents', staff and board meetings. The risk register was reviewed, as was a fire risk assessment report commissioned by the provider following the last inspection of this centre. The findings of this report, and the failure of the provider to address any of the matters raised since it was received in

January 2022 resulted in a second urgent action being issued. This will be outlined further in the 'Quality and safety' section of this report. Inspectors also looked at a sample of residents' individual files. As this was a risk based inspection focused on a limited number of regulations, only certain elements of the residents' personal plans were reviewed.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

Significant improvements were required to the governance and management of the centre to ensure that there were clear management and reporting structures, including oversight systems, in place to facilitate the delivery of a safe, sustainable, high quality service to the residents.

At the time of this inspection there was no person in charge appointed in the centre. This was also a finding of the September 2021 inspection. It is a requirement of the regulations that the registered provider appoint a person in charge. HIQA had been notified that this position was vacant and informed of the procedures and arrangements in place for the management of the centre in the absence of a person in charge, as is required. However, 28 days later the position had not been filled and the senior manager nominated to fulfil these responsibilities was absent and not expected to return within 28 days. This was one of several key roles not sufficiently staffed in the centre. As outlined in the opening section of this report, these findings prompted an urgent action where the provider had to provide assurances within a timeframe specified by HIQA.

It is a requirement of the regulations that the registered provider, or a person nominated by the registered provider, carry out an unannounced visit to the designated centre at least once every six months to monitor the safety and quality of care and support provided. Following this visit, it is required to prepare a written report and put a plan in place to address any concerns. In the September 2021 inspection of this centre, it was identified that the reports written following the unannounced visits were not comprehensive, did not review many aspects of the care and support specified in the regulations and, despite the findings of that inspection, had not identified any areas where improvement was required. In the compliance plan submitted following that inspection, the provider had committed to using a different template more aligned to the regulations. Senior management had also advised the inspector that another person had been identified to complete these required activities. During this inspection, inspectors reviewed the unannounced visit report completed in December 2021. This was completed by the same person, using the same format as the previous visits and again did not identify

any areas for improvement. This indicated that the visits were not effectively monitoring the safety and quality of care and support provided, and that the provider had not implemented the compliance plan they submitted to HIQA.

It was identified that the centre was not sufficiently resourced. There was often only one staff working in the centre when supporting a number of residents who at times required support from two staff. It was during one such time that it was alleged that the centre had been left unattended. As stated previously, this allegation came to light in the course of this inspection and had not been notified to HIQA, as required by the regulations. A retrospective notification was submitted to HIQA regarding this alleged incident before the end of this inspection. When asked how they supported residents with these assessed needs when working alone, staff told inspectors that they contacted staff in the day service based in the same building for assistance. These staff were not part of the staff complement assigned to the designated centre and did not report to the person in charge management role.

At the time of the last inspection of this centre, the person who fulfilled the roles of designated officer and complaints officer had recently left the service. The provider's safeguarding policy makes reference to the roles and responsibilities to be completed by the centre's designated officer. Although a staff member had expressed an interest in taking on this role, they had yet to receive any training on how to fulfil these responsibilities six months later. Management informed inspectors that they had sent a request for this training the day prior to this inspection. In the absence of a designated officer, staff reported to inspectors that they were unsure who to go to when they had safeguarding concerns regarding the residents in the centre. Similarly staff had expressed that in the absence of some staff (due to their rostered working hours) they did not always know who to contact for support, guidance and direction. As referenced in the opening section of this report, when staff had raised issues they did not feel that their concerns were addressed. Some staff expressed a reluctance to raise these matters again although they were ongoing. These findings indicated that in addition to the absence of effective management and oversight systems and a clearly defined management structure, effective arrangements were not in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Although a person had been identified to fulfil the role of complaints officer, they only worked two shifts a week in the centre, both starting in the evening. Although staff and some residents spoken with by inspectors said that a complaint could be reported to any member of the staff team, one resident expressed that they would only report a complaint to the nominated complaints officer as they had learned from experience to 'go through the proper channels'. This resulted in a situation where some residents felt that they could not report a complaint for the majority of the week and the complaints officer had very limited time to fulfil the responsibilities of this role as well as their other assigned duties.

Only one complaint was recorded in the complaints log since the last HIQA inspection of the centre. There was evidence that this had been investigated and responded to promptly. It was documented that the complainant was satisfied with both the outcome of their complaint and the manner in which it was addressed.

Although not recorded in the complaints log, two other incidents documented in the centre began with a resident making a complaint or making a comment that was perceived as a complaint. After consideration and liaison with others, management decided to address these matters through the provider's safeguarding procedures rather than the complaints process. These were ongoing at the time of this inspection. From review of documentation and from speaking with various members of staff and one of the residents involved, it was clear that both residents had been adversely affected by making a complaint. It was one resident's understanding that following a complaint they made regarding a staff member's conduct, a 'counter complaint' had been made against them. They informed the inspector that they had not expected this outcome and believed they were entitled to stand up for themselves and exercise their rights. They became tearful when discussing what they described as the 'counter complaint' and described themselves as worried and 'very stressed' as a result. Inspectors did not meet with the other resident. Review of the documentation of the incident highlighted that the complaints process, as outlined in the provider's own policy, had not been followed and the response from management had caused the resident upset and distress. Staff observed this distress in the days following the incident and it was also reported to them by the resident and their relatives. It was therefore concluded that the management of complaints in the centre did not ensure that any residents who made a complaint were not adversely affected by reason of the complaint having being made, as is required by the regulations.

One of the main concerns raised by staff related to the staffing levels in the centre. Inspectors reviewed a sample of staffing rosters. It was identified that for the majority of the month of February there was only one staff on duty in the centre during the day. This was not in line with the assessed needs of the residents living in the centre, many of whom required two staff to support them with personal care, including when transferring or being supported with the use of hoists throughout the day. The scores from an assessment of four residents' performance in activities of daily living indicated they had a severe level of dependency. Other residents had been assessed as requiring support and supervision at mealtimes to mitigate against the risk of choking or aspiration. Fire safety documentation reviewed indicated that many residents required staff support to evacuate. Aside from these evident safety risks, records also indicated that residents did not like to be rushed when receiving staff support with personal care or other support needs. It was therefore concluded that the number of staff in the centre was not appropriate to the number and assessed needs of the residents.

Regulation 14: Persons in charge

There was no person in charge appointed in the centre, as is required by the regulations.

Judgment: Not compliant

Regulation 15: Staffing

The registered provider had not ensured that the number of staff was appropriate to the number and assessed needs of the residents living in the centre. Many residents were assessed as requiring support from two staff throughout the day for various activities including mealtimes and personal care. Despite this there was often only one staff member on duty during the day. Review of the rosters also indicated that staff were regularly working in excess of their rostered hours.

Judgment: Not compliant

Regulation 23: Governance and management

Staffing levels indicated that the designated centre was not sufficiently resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. There was not a clearly defined management structure or management systems in place with many key positions vacant or partially filled. The findings of this inspection indicated that oversight in the centre required improvement so as to both identify and address areas where improvement was required. As a result the provider had failed to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. A number of the actions to be completed, as outlined by the provider in their compliance plan submitted following the last inspection, had not been completed. This included a commitment to complete more comprehensive reports following the required unannounced visits to monitor the safety and quality of care and support provided in the centre.

Judgment: Not compliant

Regulation 31: Notification of incidents

An alleged incident of abuse of residents was not reported to HIQA, as is required by the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

A review of documentation and conversations with staff and a resident

demonstrated that residents who had made complaints experienced emotional distress due to the responses of some staff to these complaints. The registered provider had therefore not ensured that any resident who made a complaint was not adversely affected by reason of the complaint having been made.

Judgment: Not compliant

Quality and safety

Residents reported to be happy living in the centre. Throughout this inspection the support provided by staff was respectful, unhurried and person-centred. It was clear during this inspection that positive and trusting relationships had been developed between residents and those who were working in the centre. Despite these observations, there was a poor level of compliance with the regulations inspected. These findings were consistent with, and directly impacted by, the governance shortcomings outlined in the previous section. The absence of effective management systems in the centre had resulted in the safeguarding policy not being implemented, limited opportunities for staff to support residents to participate in meaningful activities, insufficient risk assessment and inadequate fire safety precautions in the centre.

As outlined in the opening section of this report, only a selection of regulations were reviewed as part of this risk based inspection. The residents who spoke with the inspectors were positive about many aspects of the care and support provided, with all spoken with reporting that they felt safe in the centre. Based on the information received that prompted this inspection, inspectors reviewed the provider's policy and the processes and procedures in place to ensure residents were protected from all forms of abuse. As outlined previously, despite being a key role identified in the provider's safeguarding policy, there was no appointed and suitably trained designated officer. This position had been vacant since July 2021. At the time of this inspection there were two incidents of alleged abuse of residents pending investigation in the centre. Members of the management team had liaised with the local Health Service Executive (HSE) safeguarding and protection team and had acted on all recommendations given to date. In the course of the inspection, another allegation was reported verbally to inspectors. This related to an incident where it was alleged that there were no staff in the centre for a period of time when residents who required staff support were present. This incident had not been subject to the provider's own policy or reported to HIQA or the HSE, as is required.

In addition to the safety risks highlighted previously, the staffing levels in the centre also negatively impacted on residents' opportunities to participate in activities and to develop and maintain their relationships with their wider community. Residents' personal plans included activity schedules. Some activity schedules made reference to going for a walk with staff in the afternoon. Given the staffing levels outlined on

the staff roster, it was not possible for staff to support these activities as planned.

It was stated in the centre's statement of purpose that residents would be encouraged to participate in leisure and social activities within the centre and the community. From a review of a selection of residents' plans, it was noted that a number of the evening activities were identical for a number of residents. These included cards, bingo, quizzes and board games. There was no evidence to document that these plans were developed and reviewed in line with residents' choices and preferences. There was limited evidence of staff supporting residents to participate in community based activities. Where documented, outings for residents were mostly supported by family members or personal assistants.

One resident spoke with an inspector about previous difficulties they had in accessing transport supports from the provider. They told the inspector that this was something they occasionally requested, for example to attend a medical appointment. When not available, they were sometimes told it was because there would be no staff in the centre to support the other residents. They went on to say that their key worker had put a booking system in place for the centre's vehicle and this was working well. An inspector reviewed this log and identified that all of the requests noted were to facilitate medical appointments rather than any social activities.

Given the risk posed by the staffing levels to residents' safety and overall wellbeing, the centre's risk register was reviewed by inspectors. Although the register had been recently reviewed, the systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies were not effective. Although at times only one staff member was rostered to work in the centre many residents' individual support plans identified that they required support from two staff for various activities of daily living including at mealtimes and during personal care. Individual risk assessments had been completed in March 2022 however they did not reflect the impact of the centre's staffing levels or document any existing or required measures to mitigate against this risk to residents' safety and wellbeing. Centre-wide risk assessments also required review. The assessment regarding fire in the centre was reviewed in March 2022 and assessed as a low risk. This was not consistent with the findings and recommendations of a fire risk assessment report completed by a competent person in January 2022 which gave an overall moderate risk rating.

The fire risk assessment report was commissioned by the provider following a finding in the September 2021 inspection of this centre. The compliance plan submitted following that inspection stated that the report would be submitted to HIQA by 30 November 2021. A draft report dated 21 January 2022 was available in the centre and reviewed during this inspection. It was stated in the assessment report that only parts of the premises, those specific to the designated centre, were inspected. This meant that the report did not reflect the entirety of the premises, including the adjoining day service and training centre or the accommodation and living areas allocated to tenants that were interspersed throughout designated centre. The report highlighted a number of high priority areas requiring immediate action. These included the need for a revised evacuation strategy and review of

residents' personal evacuation plans, repairs to fire doors and creating and maintaining a fire safety training matrix for staff. Other actions to be addressed immediately included servicing the emergency lighting system, fire stopping in the boiler house and inspections of the earthing systems, electrical installations, appliances and equipment in the building. At the time of this inspection none of these recommended actions had been progressed by the provider.

The registered provider maintained a fire and safety register that indicated eight to ten residents lived in the designated centre at any one time. An inspector reviewed the personal emergency evacuation plans (PEEPs) in place for the residents. It was stated in five residents' PEEPs that if a fire was to occur at night when they were in bed that the resident was to await the fire brigade service to evacuate them. This approach to fire safety is not compliant with the regulatory requirement that the provider has adequate arrangements for evacuating all persons in the centre and bringing them to safe locations. Staff on duty on the day of inspection reported that they would attempt to evacuate each resident in such circumstances, in contravention of the documented plans. The direction regarding awaiting personnel from the fire service was removed from residents' PEEPs by the close of this inspection.

Two staff worked in the centre overnight, both working a sleepover shift. The fire alarm panel was located in the reception area of the designated centre. For staff to review this panel, in the event of the alarm sounding, they would be required to walk towards the centre's laundry room and commercial kitchen, both high risk areas for fire. Staff informed the inspector that two two-way radios or walkie talkies were to be used as part of the fire evacuation response. These were located in the reception area, where one was identified as not working. Staff on duty reported that they were unsure regarding how and when to use the walkie talkies. Staff also reported that they were required to support tenants with physical and sensory disabilities to evacuate from the centre. These tenants lived in the same building but not within the designated centre. The responsibilities regarding these tenants had not been reflected in any of the provider's fire documentation reviewed by the inspector.

It is also a requirement of the regulations to have effective fire containment measures. An inspector reviewed a sample of the fire doors installed in the centre. Gaps of more than 4mm were observed between the doors and doorframes. This compromised the effectiveness of the doors in preventing the spread of fire, smoke and gases if required in the event of a fire.

In light of the inaction in response to information outlined in the fire risk assessment report and the inspectors' own findings regarding fire safety, an urgent action was issued to the provider regarding fire precautions in the centre.

Regulation 13: General welfare and development

Residents were not provided with opportunities to participate in activities in line with

their individual interests where staff support was required or requested. Many activity schedules were identical and did not reflect individuals' preferences. Other activities outlined would not be possible due to the staffing levels in the centre at the times.There were very limited opportunities for residents to be supported by staff to engage in activities outside the centre, thereby impeding their abilities to develop and maintain links with the wider community.

Judgment: Not compliant

Regulation 26: Risk management procedures

Although recently reviewed, individual and centre-wide risk assessments did not accurately reflect the hazards present in the centre and the adverse impact they posed. Individual risk assessments for residents who required support from two staff at regular intervals did not take into account the staffing levels in the centre that could not meet these requirements. The actions identified as high priority and requiring immediate action in a fire risk assessment report commissioned by provider had not been progressed since the report was received in January 2022. These were not reflected in the provider's own risk assessment which assessed fire as a low risk in the centre.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had not ensured that effective fire safety management systems were in place. The personal emergency evacuation plans in place for some residents did not include evacuating them to safe locations. Several fire doors in the centre had been assessed as requiring adjustment so that they could be effective containment measures in the event of a fire. Staff were not fully aware of the procedures to be followed in the event of a fire. A recently completed fire safety risk assessment indicated several high priority actions to be addressed immediately. These included revising the evacuation strategy, testing of some fire safety and electrical appliances and equipment.

Judgment: Not compliant

Regulation 8: Protection

There was no designated officer in place, as required by the provider's own policy.

This role was vacant since July 2021. A finding on the day of inspection was that the centre was allegedly left unattended for a period of time. This incident had not been reported or subject to the provider's own safeguarding and protection policy.
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Abode Doorway to Life CLG OSV-0002411

Inspection ID: MON-0036390

Date of inspection: 10/03/2022 and 11/03/2022

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: 1. A Person in Charge was appointed to the Designated Centre on the 29th of March 2022.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. The staffing roster was reviewed and there are now two staff scheduled for duty each weekday and three staff on duty each weekend day, with effect from the 14th March 2022. 2. A waking night staff was put in place, with effect from the 16th of March 2022. 3. The recruitment of on Social Care Worker and 2 Healthcare Assistants commenced on the 15th March 2022 and is ongoing.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. Responsibilities for key areas and reporting structures were clarified for staff and residents on the 11th March 2022.

2. Refresher training will be provided to the Board Directors on the Health Act (2007) and associated Regulations and Directors and the Providers responsibilities on these by the 31 May 2022

3. Regulatory compliance will become a major standing agenda item for all Board meetings with effect from the 28th of March 2022, to ensure that the Board, as Provider, is fully overseeing and monitoring Regulatory compliance.

4. The Board has commissioned an independent external expert to carry out the 6-monthly unannounced Provider Visits in line with Regulation 23 (2), on behalf of the Board. This will include the provision of comprehensive reports of these visits to the Board. This will also provide an independent assurance to the Board on core governance issues.

5. All key management positions are being actively recruited for.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
1. The alleged incident of abuse was reported to the Authority on the 11th March 2022.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. The Complaints log includes a "Complaints Resolution Feedback" Section, which details the satisfaction of complainants with complaints.

2. Designated Centre staff completed HSE land Communicating with Persons with an Intellectual Disability training by the 4th of April 2022.

3. All Designated Centre staff will complete Complaints training by the 31st of May 2022.

4. Posters for residents on complaints have been revised, advising them on the complaints procedure and who they can contact.

5. Support has been provided to residents regarding complaints made.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
1. The staffing roster was reviewed and there are now two staff scheduled for duty each weekday and three staff on duty each weekend day, with effect from the 14th of March 2022.This will facilitate leisure and social activities.

2. A volunteer bus driver has been engaged for weekend social outings and commenced vehicle orientation training on the 1st of April 2022.

3. Individual timetables have been put in place for residents' leisure and social activities, in line with their choices and preferences.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. The Centre's Fire Risk Assessment and Management Plan was revised and updated on the 13th of March 2022.

2. A Risk Assessment and Management Plan was completed on the 13th of March 2022, in relation to the risk presented to residents and staff as a result of staffing levels. Additional controls were implemented, including the revision of the Roster and a robust recruitment drive.

3. Actions identified as required in the fire risk assessment report of January 2022 have commenced (see below under regulation 28).

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. The Fire Risk Assessment issued on the 31st of January 2022 has been updated to include the full building.

2. Actions identified as required in the Fire Risk Assessment report have commenced. Specifically: -

a) Fire training was completed by all staff on the 29th of March 2022.

b) Personal Emergency Evacuation Plans (PEEPS) were revised to reflect active evacuation on the 11th of March 2022.

c) All staff and residents were informed of the revised PEEPS by the 15th of March 2022.

d) The phased Fire Evacuation plan was revised on the 4th of April 2022, as an update to an interim plan which was put in place on the 15th of March 2022.

e) An Electrical Periodic inspection was carried out on the 24th of March 2022.

f) "Pat Testing" was completed on the 22nd of March 2022.

g) The Ansul Suppression system was assessed and certified on the 28th of March 2022.

h) Repairs on fire doors commenced on the 23rd of March 2022.

i) An updated Fire Safety Register was put in place at the end of February 2022.

j) The Automatic Openable Vents were services on the 30th of March 2022.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. A Designated Officer is now in place and this person completed their Designated Officer training on the 6th of April 2022.

2. One other staff member has commenced safeguarding / Designated Officer training, and this will be completed by the 31st of May 2022. This person will support the Designated Officer in her duties.

3. The alleged incident of abuse was reported to the Authority on the 11th of March

2022.

4. A Trust in Care Process has commenced and is underway.

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 13(1)	The registered provider shall 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	14/03/2022
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	10/04/2022
Regulation 13(2)(c)	The registered provider shall provide the	Not Compliant	Orange	24/04/2022

	following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.			
Regulation 14(1)	The registered provider shall appoint a person in charge of the designated centre.	Not Compliant	Orange	29/03/2022
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/06/2022
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	16/03/2022
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the	Not Compliant	Orange	11/03/2022

	lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.			
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	11/03/2022
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.	Not Compliant	Orange	31/05/2022
Regulation 23(3)(b)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality	Not Compliant	Orange	31/05/2022

	and safety of the care and support provided to residents.			
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	Orange	13/03/2022
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Red	14/03/2022
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	30/05/2022
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	01/04/2022
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	30/11/2021
Regulation 28(3)(a)	The registered provider shall make adequate	Substantially Compliant	Yellow	30/05/2022

	arrangements for detecting, containing and extinguishing fires.			
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.	Not Compliant	Red	14/03/2022
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	29/03/2022
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	11/03/2022
Regulation 34(4)	The registered provider shall ensure that any	Not Compliant	Orange	04/04/2022

	resident who has made a complaint is not adversely affected by reason of the complaint having been made.			
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	29/03/2022