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:	No.4 Fuchsia Drive
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	18 October 2021
Centre ID:	OSV-0004478
Fieldwork ID:	MON-0031497

About the designated centre

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

In this designated centre the provider aims to support people to live ordinary lives in their community in close connection with family and friends. A residential service is provided to a maximum of 15 adult residents. The designated centre is comprised of three houses in separate locations in relatively close proximity to each other. All three houses are in populated areas in the environs of the local busy town where a range of support services operated by the provider are also available to the residents. Each house can accommodate a maximum of five residents; residents share communal and dining space. The model of care is social and each house is staffed when residents are present in the house.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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
Monday 18 October 2021	09:40hrs to 19:30hrs	Caitriona Twomey	Lead
Monday 18 October 2021	09:40hrs to 19:30hrs	Aoife Healy	Support

What residents told us and what inspectors observed

Overall residents were supported to have a good quality of life. The needs of the residents varied throughout the centre. There were many examples of an individualised service being provided and residents being supported to be engaged in activities they enjoyed and to be members of their local community. Where required, residents were provided with additional supports and expertise. However improvement was required in areas of the service provided to ensure that it was safe, consistent and appropriate for the residents living there.

This centre was comprised of three houses located within a kilometre of each other in a large town in county Cork. Although the person in charge was responsible for the centre, each house was run separately. There was a social care leader and staff team allocated to each house.

At the time of this inspection, there was one vacancy in the centre. There were five residents living in two of the houses and four in another. The inspectors spent time in each house in the centre. In the course of the inspection, inspectors met with 11 of the 14 residents, and saw one other resident briefly. In addition to meeting with residents, inspectors walked around the premises, met with various staff members and also reviewed documentation. This was an unannounced inspection. 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.

The inspection began in one of the houses where five residents lived. When the inspectors arrived, a staff member was returning from dropping two residents to attend their day service. Shortly afterwards they supported a third resident to leave to attend a different day service. Inspectors saw this resident as they left the house but did not have an opportunity to meet with them. Eight residents had resumed attending their day services in the week prior to this inspection.

The other staff on duty greeted the inspectors and spoke to them about the residents living in the house. One resident was due to be collected by staff later that morning following a stay with their family and the fifth resident, who was in the house at the time, was going to accompany staff and go for a coffee on the way there. The person in charge met with the inspectors in this house, and in each of the others as the inspection continued throughout the day.

The inspectors met with two of the residents in the first house they visited. One was relaxing in their bedroom and appeared very much at ease. The resident spoke briefly about the people in the photographs on display in their bedroom and what they were watching on television. It was explained to the inspectors that due to changes in this person's needs in the last two years, they no longer attended a day service and instead were supported by residential staff to engage in preferred activities. Inspectors heard that staff had set up a small polytunnel and this resident

now enjoyed gardening in the fine weather. These changes had also resulted in the resident moving to a downstairs bedroom. The second resident met with the inspectors following their return from a weekend stay with their family. This resident spoke with the inspectors about their relatives, places they had been on holidays, and their day service. They were due to go to their day service the following day and were looking forward to this.

This house had recently been reconfigured to create a separate living area for one resident with a bathroom, bedroom, and combination kitchenette and sitting room. There was a door connecting this area to the main house, however since July 2021 it was locked and only used in two specific circumstances. These were in the case of an emergency, such as a fire, or when the other resident with a downstairs bedroom used the bathroom to shower. Staff explained that as a result of this arrangement, this resident only showered when the resident who lived in the separate living area was not in the house. The person in charge advised that both residents had agreed to this sharing arrangement and there was written documentation available to illustrate this. It was acknowledged by the person in charge that this arrangement was not ideal and the provider planned to build an extension to this property to address this and other accommodation issues in the house. The inspectors had seen the planning notice regarding these plans on their arrival to the centre. It was accepted that this building did not meet the assessed needs of the residents living there.

When walking around this house, the inspectors identified many areas that required maintenance. The most striking of these was the ceiling in the shared, downstairs bathroom which was covered with mould. This posed a risk to the wellbeing of the two residents' who used this bathroom. The person in charge advised inspectors that this was a recurrent issue that was routinely cleaned. The source of this problem had not been effectively addressed. This issue was reported to be exacerbated by one resident's refusal to leave the bathroom window open. Maintenance staff were scheduled to visit the centre on the day of this inspection and arrived while inspectors were there. It was also noted by inspectors that although they had been assessed as necessary to meet the needs of one of the residents, hand rails were not fitted in this bathroom. Other premises issues included areas to be repainted, flooring that was lifting in parts of the kitchen, and areas of the self-contained area that required cleaning.

Other identified issues posed risks regarding fire safety. These included a closing mechanism on one door that had required repair for over a year, a hole in a bedroom fire door following the removal of a keypad, and the routine locking of one fire exit by night. The person in charge explained that a risk assessment had been completed regarding the practice of locking the fire exit. Measures to mitigate this risk included staff carrying a key to this door at all times. Staff who worked at night were based in the other section of the house. Prior to this inspection, the Health Information and Quality Authority (HIQA) had been informed that this fire exit door had been installed as without it the bedroom would be an inner room. This would mean that a resident could only exit this area by passing through another room, which now included a kitchenette. The inspector requested that a competent person assess if the practice of routinely locking the fire exit of an inner room at night, with

the outlined control measures, posed a high risk to the resident's safety.

It was also observed that a cupboard in this house used to store biscuits and other sweet foods was locked. This had not been reported to HIQA as a restrictive practice. The person in charge informed inspectors that this was not usual practice and ensured that the door was unlocked. While in this house, inspectors also reviewed the complaints log and identified areas requiring improvement. These will be outlined in the Capacity and capability section of this report.

Five residents also lived in the second house that the inspectors visited. This group were described as enjoying active retirement. When the inspectors arrived, four residents were participating in an online music session and the fifth was resting in their bedroom. One inspector met with the social care leader and reviewed documentation including the staff roster, training records and a sample of residents' individual files. The other inspector spent time with the residents.

The four residents expressed their satisfaction with living in the house and described it as their home. They introduced themselves to one of the inspectors and told them about their families, where they were from, and asked the inspector about themselves. They also spoke about the online music class and other activities that they participate in such as art, watching DVDs, doing Zumba classes and meditation. Residents described their weekly timetable of activities and the inspector saw this being implemented on the day. Residents also spoke about going for walks and out for tea in the local town. One resident spoke about one of their relatives who visits them in the house and the other residents spoke about how much they look forward to this person visiting also. Residents appeared to get on well with each other and clearly knew each other very well. The inspector was told about how they choose their meals and the menu on display in the kitchen. Later the resident who had been resting in their room met with one inspector. Staff supported this resident to tell the inspector about their artwork, explaining that one piece had been bought by a local celebrity. The resident showed the inspector some of their artwork that was on display in the house.

One resident showed the inspector around the house, including their bedroom. This was decorated with the resident's belongings, including photographs of their family, who the resident was proud to tell the inspector about. There was a large sitting room and kitchen in this house. On leaving the house, it was identified that the fire door in the kitchen was not closing properly. This required review. At the time of the last HIQA inspection in July 2019, it was identified that this house did not meet the assessed needs of the residents. Although spacious and well maintained, this two-storey house was not suitable for many of the residents given their assessed mobility needs. The impact of this was that one resident used another resident's ensuite bathroom to shower, while the resident with the ensuite bathroom showered upstairs despite assessments saying that this was not appropriate or safe for them. Another resident whose bedroom was upstairs was using a peer's downstairs bedroom throughout the day for elements of personal care so as to spare them repeated use of the stairs. It was not possible to use the downstairs communal bathroom as it was not big enough to facilitate this activity. The provider was forthcoming about these issues and had risk assessed them. Since the last

inspection alternative properties had been sought but none were found in the local area. It was important to this group to continue living in this town. The person in charge informed inspectors that there were plans underway regarding building an extension to this property also.

The third and final property visited by the inspectors was a three-storey house where four residents lived. Each resident enjoyed good physical health and had no difficulty accessing any areas of the house. One resident in this house had access to a room for their exclusive use. They were completing a jigsaw with the support of staff when the inspectors arrived. Another resident was eagerly awaiting the inspectors' arrival and gave one a tour of the house, including their own bedroom. This resident took responsibility for cleaning their bedroom and was visibly proud of this. They were happy to speak with the inspector about the people in the photographs displayed on their wall, and some of their recent purchases including a new coat for the winter ahead. They were very knowledgeable about the day-to-day running of the centre and were happy to share this information. They expressed that they were happy with their living situation. Another resident spent some time sitting on the couch in the office while the inspectors reviewed some documentation. They appeared very much at ease there and it was clear that they were welcome to spend time in all parts of their home. The fourth resident was out on the inspectors' arrival but returned before they left and briefly spent time in their company.

The other inspector was shown parts of the house by the social care leader. While doing this it was identified that a self-closing mechanism was not working and a bedroom doorframe, including the fire seal, had been painted. This required reviewed to ensure that, if required, the seal would still prevent the spread of smoke, gases and fire. Fire drill records were reviewed in this house. It was identified that one year prior to this inspection, one resident had refused to participate in a drill with night-time staffing levels. Despite this incomplete evacuation, another drill with these staffing levels had not been repeated since and there was no evidence that additional support had been sought or provided to encourage this resident's future participation.

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

The findings of this inspection indicated that while there was evidence of strong oversight of some areas of the service provided in the centre, others required improvement. Poor findings regarding fire safety were identified throughout the centre. Additional input was required to protect the residents of one house from infection.Other areas requiring improvement were also identified. In the July 2019

HIQA inspection of this centre, it was identified that the provider was not compliant with the regulation regarding premises. Although it was noted that efforts had been made in the interim and a plan was proposed at the time of this inspection, the premises were not suitable for residents' assessed needs in two of the three houses in the centre. The provider needed to further improve the overall governance and management of the centre in order to ensure effective oversight and sustainable, consistent and safe delivery of care.

There was a clearly-defined management structure in place that identified lines of accountability and responsibility. Support staff in each house reported to the social care leader, who reported to the person in charge, who reported to the person participating in management. At the time of the last HIQA inspection of this centre there had been recent changes to members of the management team and more were planned. At the time of this inspection there was a social care leader appointed to each house. In the previous 12 months, both a new person in charge and person participating in management had been appointed. It was evident that all members of the management team were very familiar with the residents living in the centre and their support needs.

There were consistent staff teams working in all three houses in the centre. This ensured that residents received a continuity of care and were supported by teams of staff who knew them well. Staff who spoke with inspectors were very knowledgeable about the residents. There were planned and actual staff rotas in place. Staffing levels had increased in the centre since the last HIQA inspection. This was a welcome improvement. The statement of purpose required review to reflect this change. Inspectors reviewed the training records of the staff team working in one of the houses. All staff had attended the training identified as mandatory in the regulations.

The provider had completed an annual review, as is required by the regulations. The most recent review was completed in November 2020, with reference to five themes. Actions to be completed to improve the quality of the service provided were listed under each theme. It was noted that residents were to be supported to access the community in line with the easing of national restrictions. Residents and their representatives had been consulted as part of the annual review. There was limited detail in the review regarding this feedback, however the information provided indicated that the majority of feedback received was positive. It was identified that some improvement was required in the communication between residents' keyworkers and their families and in the communication from the provider to both relatives and one of the staff teams regarding a potential move to another house. Inspectors were informed that this proposed move was no longer going ahead and instead building works were to be completed in the existing property.

The person in charge informed inspectors that an unannounced visit and subsequent report on the safety and quality of care and support provided in each of the houses had been completed in recent months. Copies of these were provided. Management acknowledged that the unannounced visits had not been completed at the six-monthly intervals specified in the regulations. The most recent reports had been completed following visits in May and June 2021. Action plans were developed to

address any issues identified. However, as there had been a delay in circulating the written reports, on the day of inspection progress with implementing the actions plans was not documented. Despite this, inspectors saw evidence that there had been follow up on some of the issues identified.

The person in charge spoke with the inspectors about an audit schedule that had been introduced across the organisation. This included the introduction of a fire safety audit based on guidance recently published by HIQA. Given the findings of this inspection, this was a welcome addition.

The complaints log for one of the houses was reviewed. Improvement was required in the documentation regarding complaints and the implementation of the provider's policy. While it was documented, and there was evidence on the day of inspection, that each complaint was considered and responded to, the actions taken to address these complaints were not clearly documented. For example, it stated on one entry that various responses to the resident's complaint would be considered however it was not clear what was actually done. It was also noted that every complainant was satisfied with the outcome of their complaint however it was not clear that this had always been established. The topic of one complaint was an ongoing issue at the time of the inspection. It was therefore unlikely that this complainant was satisfied. Improvements regarding establishing the satisfaction of complainants had been identified in the most recent unannounced visit report of this house. It was also identified that the provider's own complaints policy was not implemented. Complaints that were not resolved within 30 days had not been escalated to the provider's complaints officer.

Regulation 14: Persons in charge

The person in charge was employed on a full-time basis and had the skills, qualifications and experience necessary to manage the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The planned and actual staff rota was well maintained. Despite recent changes to management, a consistent staff team was in place at the time of the inspection. Personnel files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Of the sample reviewed, all staff had completed all mandatory training, as specified in the regulations.

Judgment: Compliant

Regulation 21: Records

Not all records in relation to each resident had been accurately maintained. This posed a risk as the most up-to-date and accurate information about residents was not readily available to the staff team supporting them.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was evidence that the the designated centre was not sufficiently resourced. Non-compliances regarding the premises of one house identified in July 2019 had not been addressed, and at the time of this inspection it was assessed that two of the three premises did not meet residents' assessed needs. Not all recommendations from multidisciplinary reviews had been implemented.

The management systems in place did not ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored. This was evidenced by the findings throughout the centre regarding fire precautions and the findings relating to protection from infection. Improvement was also required in the development and review of resident's plans, maintenance of documentation, and the centre's risk register.

It was also identified that the unannounced visits to review the quality and safety of care provided in the centre did not take place at the frequency required by the regulations.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required review to accurately reflect the staffing in the

centre.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

The registered provider had responded appropriately to all complaints but improvement was required in documenting the actions completed in response to complaints and in assessing and documenting the complainant's satisfaction with the outcome of their complaint. The requirement, as outlined in the provider's policy, to escalate complaints after 30 days had not been followed.

Judgment: Substantially compliant

Quality and safety

The inspectors found that the quality and safety of care provided in the centre was of a good standard in some areas and required improvement in others. A review of documentation and the inspector's observations indicated that many residents enjoyed living in this centre and that the staff teams in each house strived to support residents to enjoy a good quality of life. There were longstanding issues in the centre regarding the premises. Previously this only related to one house but that the time of this inspection two of three houses in the centre were not suitable for the assessed needs of the residents. Significant improvement was also required throughout the centre in relation to fire safety and in one house regarding protection from infection. Others areas to be addressed included the development and review of resident's plans, maintenance of documentation and the centre's risk register.

This centre was comprised of three houses. Residents in one house had developed strong relationships with each other and had clearly communicated their wishes to continue living together as a group. These residents all knew each other's relatives and enjoyed welcoming visitors to their home. As outlined in the opening section of this report they had a busy schedule of activities. There had been some identified incompatibility issues between residents in the other two houses. The provider had implemented some effective measures to address these incompatibilities. Some residents in one of the houses were happily sharing communal parts of the house when inspectors visited and others were spending time alone, in a less busy environment. At the time of this inspection, one resident was going through a prolonged period of distress. There was evidence that additional supports had been put in place to support this resident and meetings with input from multidisciplinary professionals were occurring on a regular basis to review and develop intervention

and support strategies. The resident was also regularly receiving one-to-support from various professionals. The person in charge told inspectors that there had been some improvement in recent weeks with the resident choosing to participate in more activities. However significant further improvement was required for this resident to return to enjoying the quality of life they previously enjoyed in the centre.

Inspectors reviewed a sample of residents' individual files in each house in the centre. These included a life story summary which provided key information about the person's personal history and the important people in their lives. The majority of plans included a review involving multidisciplinary professionals completed in the last 12 months. Where these had not been completed a multidisciplinary review was scheduled for the following month. It was identified that the recommendations made in some multidisciplinary reviews had not been implemented. In one, it was recommended that the staff team in one house complete training in autism, however 12 months later this had not occurred.

These files also included plans to maximise residents' personal development in accordance with their wishes, as is required by the regulations. Goals outlined what each resident wanted to achieve in the year. The provider's personal planning process indicated that goals were to be reviewed quarterly, however it was noted that this did not always occur. In addition, at the time of this inspection one resident did not have a current personal development plan.

Residents' healthcare needs were well met in the centre with timely and appropriate access to general practitioners, specialist consultants and allied health professionals, as required. Where a healthcare need was identified, a corresponding plan was in place. Residents and staff had access to the support of a community nurse from Monday to Friday. Although recommendations from allied health care professionals were documented, it was not always possible to tell if they were implemented, for example, if residents were performing prescribed exercises and at the required frequency.

This was one of the many areas for improvement identified regarding the documentation kept in the centre. It was also noted that some residents' files had multiple versions of documents that were not consistent with each other, for example, care plans and weekly schedules. Other information was not up to date, for example, there was reference to one resident having socially distant visits with their family. The person in charge told inspectors that this was no longer the case and that this resident now enjoyed visits with their family in line with the current national public health guidance. It was also identified that not all care plans were consistent with each other. In one resident's file, one care plan made reference to their recent weight loss while another referenced their ongoing weight gain. The poor maintenance of documentation posed a risk as the most up-to-date and accurate information about residents was not readily available to the staff team supporting them.

As outlined in the first section of this report the premises in two of the three houses required significant improvement to ensure they were accessible and met residents' assessed needs. The provider had plans to complete building works in these houses

but there was no clear timeline for these works to occur. It was also identified that rooms assigned as second sitting rooms in two of the houses were primarily used for storage. Areas requiring cleaning and maintenance were also identified in two houses in the centre.

Inspectors identified non-compliances with the regulation regarding fire precautions in each house of this centre. There was at least one door in each house in the centre that required review to ensure that is closed properly and could therefore be an effective containment measure, if required, in the event of a fire. Ineffective or damaged door closing mechanisms were also seen in two houses. In one instance, this was a longstanding issue that had been documented in a six-monthly visit report completed one year prior to this inspection and regularly in staff checks since. The fire seal had been painted over in a bedroom doorframe in one house. In another house, a hole was observed in a fire door fitted to a bedroom. Inspectors were informed at the close of this inspection that a replacement door had been ordered. Review by a competent person was also required regarding the ongoing practice of locking by night a fire exit installed to an inner room used as a resident's bedroom.

Inspectors reviewed records which showed that one resident had refused to evacuate during a night-time fire drill completed one year prior to this inspection. Despite this, a similar drill had not been repeated since and additional supports had not been sought or added to this resident's personal emergency evacuation plan (PEEP). This had not been raised at the resident's multidisciplinary review held the month following the incomplete drill, and had also not been risk assessed or included in the house's risk register. The ratings of some risk assessments viewed by an inspector also required review to ensure that they were accurate and reflective of the current situation.

Staff were observed implementing enhanced infection prevention and control (IPC) measures in place due to the ongoing COVID-19 pandemic. IPC self-assessments had been completed in each house. There was also evidence that monthly audits in this area were completed by members of the staff team. Procedures were in place regarding residents spending time in their family homes and then returning to the centre. A COVID-19 contingency and outbreak plan was in place and an IPC lead was identified. Roles and responsibilities in relation to IPC were clearly identified, including details of contacts in the event of a suspected or actual outbreak of COVID-19. Staffing arrangements in the event of staff shortages were also outlined. A sample of cleaning and enhanced cleaning rosters were reviewed on the day of inspection and were found to be signed by staff on duty. However the unclean floors and surfaces observed and the recurrent mould present throughout the bathroom ceiling used by two residents in one house posed a healthcare risk and was not consistent with protecting residents from infection.

Regulation 11: Visits

Residents were supported to receive visitors in line with their wishes. Due to the ongoing COVID-19 pandemic, there were specific guidelines in place to facilitate visitors.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had opportunities to participate in activities in line with their wishes, interests and assessed needs. They were members of their local community and many had developed a strong attachment to the town. Some residents had resumed attending their day services. Others were enjoying an active retirement model of service and picked and chose the activities they participated in.

Judgment: Compliant

Regulation 17: Premises

The premises in two of the three houses did not meet the assessed needs of, and were not accessible to, the residents living there. As a result, one resident was using an upstairs bathroom despite recommendations that they not use the stairs. Another resident was having their personal care needs met in a peer's bedroom. To access a shower, one resident was using a peer's ensuite bathroom and another was going into what was described as another peer's a self-contained living area. It was also identified that parts of the centre required maintenance and cleaning.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents were supported to prepare and cook their own meals in line with their wishes. The food provided was wholesome and nutritious and residents were offered and supported to make choices at meal times.

Judgment: Compliant

Regulation 26: Risk management procedures

Not all hazards in the centre had been identified. These included an identified incompatibility in the centre and one resident's refusal to evacuate during a night-time fire drill. As a result the risks associated with them had not been assessed. The ratings of the impact of some hazards also required review to ensure they were accurate.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Although there was evidence of strong adherence to infection prevention and control measures implemented as part of the provider's response to the COVID-19 pandemic, the areas identified requiring cleaning and the recurrent mould throughout the ceiling in one shared bathroom posed a risk to residents' health and wellbeing.

Judgment: Not compliant

Regulation 28: Fire precautions

Effective containment measures were not in place. At least one door in each centre required review to ensure that it would close fully if required in the event of a fire. Damaged door closing mechanisms were observed in two houses. One fire door had a hole in it. The fire seal on a door in another centre had been painted over.

A competent person needed to assess the risk posed by the practice of locking the fire exit to one resident's bedroom which was an inner room, given the mitigation measures in place.

The fire evacuation drill completed in night-time conditions in one house was incomplete with one resident not participating. This was not reflected in their personal emergency evacuation plan (PEEP). It was not demonstrated that the provider could evacuate, where necessary in the event of fire, all persons in the designated centre and bring them to safe locations.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Not all residents had a current personal development plan. Goals outlined in residents' personal developmental plans were not reviewed at the frequency

outlined in the provider's policies and procedures. Not all multidisciplinary reviews reflected changes in resident's needs or circumstances.

Judgment: Substantially compliant

Regulation 6: Health care

Residents' healthcare needs were well met in the centre. Residents had access to medical practitioners and allied health professionals as required.

Judgment: Compliant

Regulation 8: Protection

Safeguarding concerns had been addressed in line with national policy. Of the sample reviewed, all staff had received training in relation to safeguarding residents and the prevention, detection, and response to abuse.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for No.4 Fuchsia Drive OSV-0004478

Inspection ID: MON-0031497

Date of inspection: 18/10/2021

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: The Provider will ensure that the Person in Charge and keyworkers will review each persons supported personal plan to ensure they are reviewed within adequate timeframes and contain the most up to date and accurate information for each person supported.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider has ensured that - Plans are in place to address the suitability of the premises. Planning permission has been approved for extensions to two of the houses within the designated Centre. Once complete these extensions will ensure each house meets the needs of each person supported. - the PPIM in conjunction with the person in charge will review each houses risk register to ensure all identified risks are included on the risk register - The person in charge will undertake a quarterly fire audit as part of a suite of audits to be undertaken over a period of twelve months to ensure effective monitoring of the designated Centre. - The PIC in conjunction with the keyworkers will review each persons supported	

personal plan to ensure they are reviewed within adequate timeframes and contain the most up to date and accurate information for each person supported.

- Unannounced Provider visits will occur every six months and these reports will be distributed in a timely manner to the person in charge.

Communications with residents and family members in relation to alterations to the premises and other significant issues are done in a planned and consistent manner to ensure factual accuracy of information provided

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The registered provider will review the statement of purpose to ensure it accurately reflects the minimum staffing levels in place in the designated Centre.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Provider will ensure that the Person in Charge will review the complaints log in each house within the designated Centre to ensure that all complaints are resolved and documentation pertaining to each complaint is completed correctly including details on whether the complaint was resolved to the satisfaction of the complainant.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The Provider will ensure that regular maintenance works are carried out in the premises and that the backlog of works during the pandemic are addressed including:-
- New flooring will be installed in the kitchen area and upstairs landing in one of the houses
- Bathroom area in apartment will be examined to find source of damp and ceiling will be

damp proofed and painted. Hand rails will be installed if recommended by multidisciplinary support staff
- Interior painting will be undertaken in one house
- A deep clean will be undertaken in each house within the designated Centre

The provider will work with the residents, their families and the staff team regarding suitable accommodation options for residents during the refurbishment works should the residents need to vacate the building during the building of the extensions. [31/03/2022]

The Provider has ensured that a Design Team and building contractors to finalise the extension works are
- Tendered for in line with procurement guidelines [31/01/2022]
- Appointed to carry out the works [28/02/2022]
- Complete the extension works to meet the changing needs of residents [31/12/2022]

The Provider will submit the appropriate Application to Vary to reflect the changes to the facilities once the works are complete [31/12/2022]

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The registered provider has ensured that the PPIM and the Person in Charge will review the Centre's risk register to ensure the risk ratings accurately reflect the risk and that each risk identified has been risk accessed including fire risk due to one person's supported refusal to evacuate during a night time drill and Care support risks should the most recent documentation not be on file to inform care giving by the staff team.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The Provider will ensure the continued implementation of Infection Control Guidelines in the Centre and has ensured that a maintenance request has been submitted to identify the source of the mould in the bathroom and rectification of same

A deep clean will be undertaken in each house within the designated Centre.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Person in Charge has ensured that a competent person will assess the risk posed by the practice of locking one of two fire exits in a bedroom, with the existing control measures in place. The Provider will recommend recommendations for further controls arising from this assessment.

A night time fire drill will be undertaken in one house and any issues arising relating to one person supported refusal to evacuate will be risk assessed and appropriate plan put in place to support person supported to evacuate safely at night time

Fire doors will be examined on a routine basis and the works listed below will be completed
- New fire door to be installed in one house
- Seals to be replaced in two fire doors in one house
- Self-closing mechanisms on three doors in three houses will be repaired

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:
The Person in charge will review each person supported personal plan with their keyworker to ensure it is reviewed within the appropriate timeframe.

Goals set at the Annual Multi-Disciplinary reviews will be reviewed by the Person in Charge to ensure they are being progressed or completed.

The Person in Charge will ensure all multi-disciplinary recommendations are followed up – to include autism training for staff members as required

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 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/12/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/03/2022
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/03/2022
Regulation 17(7)	The registered provider shall	Not Compliant	Orange	31/12/2022

	make provision for the matters set out in Schedule 6.			
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.	Substantially Compliant	Yellow	31/03/2022
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	31/01/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/01/2022
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least	Substantially Compliant	Yellow	31/01/2022

	once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	31/01/2022
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	Not Compliant	Orange	31/01/2022

	Authority.			
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/03/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/03/2022
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	Orange	31/03/2022
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	31/01/2022
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	31/01/2022

Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	28/02/2022
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	28/02/2022
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	28/02/2022