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 2 Seaholly
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	07 March 2023
Centre ID:	OSV-0004572
Fieldwork ID:	MON-0038390

About the designated centre

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

No. 2 Seaholly comprises two detached bungalows, located on a campus with a number of other designated centres operated by the same provider, on the outskirts of Cork city. The designated centre is registered to accommodate nine adults at any one time. Five residents live in one house, and four in the other. Each bungalow has its own garden area. A full-time residential service is provided to five residents in one house. In the other house, two residents live there on a full-time basis, while two others regularly stay on a respite basis. This house has a self-contained apartment, used by one resident. Each resident of No. 2 Seaholly has been diagnosed as functioning within the range associated with a moderate to severe level of intellectual disability. Some residents also have an autism diagnosis. The centre is staffed at all times.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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
Tuesday 7 March 2023	09:30hrs to 19:00hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

No. 2 Seaholly comprises two detached bungalows located beside each other on a campus on the outskirts of Cork city. This campus also includes other designated centres and a range of other services operated by the same provider. The designated centre is registered to accommodate nine adults at any one time. Five residents live in one house, and four in the other. A full-time residential service is provided to five residents in one house. In the other house, two residents live there on a full-time basis, while two others regularly stay on a respite basis. This house has a self-contained apartment, used by one resident.

This was an unannounced inspection. The inspector first visited the house where five residents lived. On arrival they were greeted by a member of the staff team. Later in the morning they met with the person in charge who facilitated the inspection. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and all staff adhered to these throughout the inspection.

When the inspector arrived, one resident had already left to attend their day service. Another resident was resting in bed, and the remaining three residents were in the living and dining room area. One resident was eating their breakfast, another was sitting down by the window, and the third was waiting for the bus to arrive to bring them to their day service. Throughout the day the inspector spent some time with all five residents. It was explained to the inspector that the resident who was still in bed preferred a quiet environment and although they had already been up that morning, they had returned to bed. Staff told the inspector that two of the residents attended a day service three days a week. Prior to the COVID-19 pandemic, both residents had attended five days a week. It was explained that prior to the reopening of day services, it was decided to try attending fewer days a week. Staff reported that this was going well and that residents appeared more content with a more relaxed pace of life, and with more time at home.

There were three staff working in the house when the inspector arrived. Staff introduced the inspector to the residents and showed them around the premises. One resident joined them for part of this tour. The house was decorated in a homely manner. Residents' photographs were on display in the large living and dining room area. There was a large television and seating options available on both sides of this room. Staff advised that this layout supported residents to have their own space while also spending time together. Some of these seats required cleaning. When in the kitchen it was noted that the counter, and the surfaces of the majority of the kitchen units were visibly damaged. A hole was seen in the flooring and the outside of the bins was unclean. Aside from these observations, it was noted that the kitchen was generally clean, well-equipped and had supplies of fresh food available.

Each resident had their own bedroom and these had been personalised in line with residents' wishes and interests. One resident had a poster of their favourite band,

while another had personalised bunting on display from a recent party. There were two communal bathrooms in this house and both were observed to be clean and well-maintained. There was also a staff office and a separate filing room. The filing room had built-in storage units for files that were to be archived. This room also contained a refrigerator that could be used to store medication if required, some cleaning equipment, some non-perishable foods, and a larger refrigerator used for food. There was also a relaxation room in this house. This room had a variety of comfortable seating options as well as some sensory-focused equipment such as lights, a projector, musical instruments and a music system. Staff advised that some residents in particular enjoyed spending time in this room. There was a garden area behind the house and a number of hanging baskets were also seen. Staff explained that during lockdown there was a focus on gardening and, due to residents enjoying this activity, it had continued.

When the person in charge arrived, the inspector was informed that it was planned for all five residents to move from this house. Four residents were to move to a house in a local town, and one resident was to move to a designated centre on another campus operated by the provider. Renovations and building works were underway in the community-based house. At the time of this inspection there was no definite completion date. Once the works were completed, the house would need to be registered as a designated centre. Although moving to a house based in the community had been discussed previously with residents' families, management advised that until there was clarity on the availability of the premises, planning would not begin to support residents with the proposed move. The inspector was informed that a transition plan had begun in 2021 for the fifth resident to move to an existing designated centre but this had stopped 18 months previously and was yet to resume. This will be discussed in more detail in the next section of this report.

When the inspector arrived in the second house, there was one resident and two staff present. The other full-time resident was at their day service, and the two residents who availed of respite were not in the centre at the time. The presence of the inspector and the person in charge in this house appeared to be unsettling for the resident. As a result, this visit was kept short so as not to cause distress. Again it was noted that residents' bedrooms were personalised to their tastes and preferences. The inspector saw a visual communication aid on display for one resident. Visual communication aids were also on display in the communal areas. As in the other house there was a large living and dining room. The living room area was homely and decorated with bright soft furnishings. There was comfortable furniture available. Although generally clean, as in the other house, cobwebs were seen in the living area. There were also a number of damaged surfaces, most noticeably on the kitchen chairs in the kitchen area. The kitchen and utility room were clean and well-organised. Although in better condition than the one in the other house, this kitchen also required repainting in places.

The inspector also briefly visited the self-contained apartment in this house. This included a bathroom, kitchen, bedroom, and two living rooms. This too was decorated in a homely manner and reflected the interests of the resident who spent time there. Management advised that this resident regularly spent time in the kitchen area as they liked to be involved in meal preparation. The provider had

informed the Chief Inspector of a resident staying in this designated centre on an emergency basis in July 2022. During this inspection, the person in charge confirmed that this had been a two night stay, and was not repeated since. To facilitate this resident, the smaller sitting room in the apartment area had been converted to a bedroom. The resident who regularly stays in this part of the centre was not present at that time. This arrangement ensured that no one else stayed in this resident's bedroom.

While in the apartment, the inspector asked to see what was stored in a locked cupboard. Medicines were stored on one side, and other items on the other. When looking at the medicines, it was observed that there was one tablet stored in a container. There was no label on this container stating the name or dose of the medicine, or who it was prescribed for. This was not consistent with the provider's policy. It was also noted that there was an empty box labelled as a PRN medicine (medicine taken only as the need arises) prescribed for the resident who regularly stays in this part of the centre. It was not clear if this empty box should have been disposed or if the medicine was currently elsewhere. These and other poor findings regarding medication management practices in the centre will be outlined in more detail in the 'Quality and safety' section of this report. It was also noted that sharp knives were stored in this cupboard, rather than in the kitchen. This restriction had not been reported to the Chief Inspector of Social Services, as required by the regulations, or subject to the provider's own restrictive practice policy.

The inspector spoke with staff working in both houses in the centre. Staff were knowledgeable about residents' needs and appeared to have developed strong working relationships with them. All interactions observed were warm, respectful, and in keeping with residents' documented personal plans. Staff demonstrated a commitment to supporting residents to lead meaningful lives of their choosing. The inspector had an opportunity to spend some time with six of the residents who lived in the centre. Residents appeared at ease in their home and with the staff support provided. Some welcomed the inspector, while others appeared unsettled that someone they did not know was in their home. Staff supported residents with these challenges and the inspector also spent a limited amount of time in one house so as not to cause distress.

As this inspection was not announced, feedback questionnaires for residents and their representatives had not been sent in advance of the inspection. The inspector did review the feedback received from some residents' relatives as part of the annual review process. Feedback was received from five respondents. This was all positive, with all reporting that they were satisfied with the service provided. One respondent referenced that staff always keep them up to date. Compliments received had also been recorded in the centre. These outlined relatives' appreciation of the care and support provided to residents. One relative referenced the progress a resident had made, while another thanked staff for supporting a resident to attend a family wedding, saying that their presence had made the day perfect.

As well as spending time with the residents in the centre and speaking with staff, the inspector also reviewed some documentation. Some documents relating to the centre were reviewed by the inspector in an administrative office on the campus.

Documents reviewed included the most recent annual review, and the reports written following the two most recent unannounced visits to monitor the safety and quality of care and support provided in the centre. These reports will be discussed further in the 'Capacity and capability' section of this report. Staff training was reviewed and was identified as requiring increased oversight in one house. The inspector also looked at the centre's complaints log and staffing rosters. The inspector read a sample of residents' individual files. These included residents' personal development plans, healthcare and other support plans. The inspector's findings will be outlined in more detail in the remainder of this report.

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

Improvement was required in the oversight of the service provided in this centre to ensure that actions were followed up as documented, that staff training was completed as required, and the provider's own policies were consistently implemented as outlined.

There were clearly-defined management structures in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. Each house had a team leader and a staff team. With the exception of some relief staff, staff were assigned to work in one house in the centre only. Social care workers, nurses and care assistants reported to a team leader. Both team leaders reported to the person in charge, who reported to the person participating in management. Neither team leader was rostered to work in the centre on the day of this inspection so the inspector did not have an opportunity to meet with them.

The person in charge fulfilled this role for two designated centres, comprising four houses in total, located on the same campus. Their remit had reduced by two designated centres in the month prior to this inspection. As a result of this change, they advised the inspector that they had not been in this centre as often as they usually would be, so far this calendar year. They advised that due to the impact of their presence on a resident in one house in the centre, they did not spend as much time in this house as in others. The person in charge advised that they met and spoke with the two team leaders several times a week, and had a group meeting with all team leaders who reported to them monthly. They also had individual supervision meetings with the team leaders, in accordance with the timeframe outlined in the provider's policy.

The inspector reviewed a sample of the minutes recorded following staff meetings held in both houses in the centre. These were facilitated by the team leaders. The

person in charge did not attend. There was evidence of communication, reflection, planning, and shared learning at these meetings. Topics referenced the day-to-day management of the centre, and both the needs of residents and the staff team. Topics discussed included any recent incidents, infection prevention and control (IPC) practices, staff training, risk assessments, staff recruitment and induction, advocacy services, holidays, birthday celebrations, residents' progress with current goals, and any upcoming appointments. These meetings provided staff with opportunities to raise any concerns they may have about the quality and safety of the care and support provided to residents to their team leaders.

The provider had completed an annual review and twice per year unannounced visits to review the quality and safety of care provided in the centre, as required by the regulations. The annual review was completed in June 2022 and, as referenced in the opening section of this report, involved consultation with residents' representatives. An unannounced visit had taken place in one house in the centre in June 2022, and in the other house in November 2022. Where identified, there was evidence that some, but not all, actions to address areas requiring improvement were being progressed or had been completed. Some of the areas identified in these audits that were also identified in the course of this inspection included poor practices in medication management, the need to paint or replace two kitchens, outstanding staff training, and ensuring each resident had a written service agreement with the provider.

Throughout this inspection, other documented actions that had not been followed up were identified by the inspector. These included actions outlined in the annual multidisciplinary review of residents' personal plans, and in the provider's assessment of the infection prevention and control (IPC) measures in place in the centre. Actions not completed included making complaints on residents' behalf, and updating the isolation and contingency plans for each house.

The complaints logs for both houses were reviewed. There had been only one complaint made since the centre was last inspected on behalf of the Chief Inspector in May 2021. This complaint, made in December 2022, referred to a decrease in the number of days that a resident could attend their day service. There was no documented follow up to this complaint. The person in charge advised that this related to the day service, rather than the designated centre, and had been addressed shortly afterwards. This was confirmed during the inspection. While the inspector was assured that the matter had been addressed in a timely manner, improvement was required to document the actions taken, the outcome, and the satisfaction of the complainant, for all complaints recorded in the designated centre.

As referenced previously, it was documented in the records of at least two residents' annual review of their personal plans that complaints be made on their behalf. The topics of these complaints were continuing to live in an environment that did not meet their needs, and limited access to transport. Although these complaints were to be made in August 2022, there was no record of them in the centre's complaints logs.

It was assessed in November 2019 that one resident was experiencing anxiety due

to their living arrangements. It was recommended that this resident move to a designated centre that could meet their assessed needs. This was referenced throughout their personal plan. A vacancy in another designated centre operated by the provider was identified and transition planning began in 2021. The inspector reviewed the transition plan which stated that a date for the resident to move was to be confirmed on 03 September 2021. At that point the transition plan stopped. Management advised the inspector that the place identified was required for an emergency admission and there had been no vacancy in that centre since. There was no documented progress regarding this matter in the last 18 months and at the time of this inspection, there was no plan for when this resident would move.

As well as being referenced in the review of residents' personal plans, in the centre's annual review staff had also advocated for transport facilities for the residents in one house. In addition, a representative of the provider included in the June 2022 unannounced visit report that a vehicle would benefit these residents. The inspector discussed the transport facilities available to residents with the person in charge. They advised that one vehicle was assigned to one house, and was available for use at all times. They had access to a second vehicle at weekends. Three of the four residents living in this house attended a day service most days, and only two lived in the centre on a full-time basis. The other house where five residents lived did not have its own vehicle. The person in charge advised that a funding request had been submitted to buy a vehicle but they did not have an update on this request on the day of inspection. It was explained that in the evenings and at the weekend, residents had access to a day service vehicle, and that this was also available at times during the day. Given the number of residents who lived in this house, their support needs, their level of attendance at day service, and the location of their home, this did not appear sufficient to ensure that residents could maintain links with their local community and enjoy community-based activities as often as they would like.

The inspector asked to review the training records of the staff working in the centre, including relief staff. A training matrix had been prepared regarding the nine staff working in one house in the centre. The matrix facilitated easy access to this information. This was not available for the ten staff working in the other house in the centre. As a result the person in charge was not able to advise the inspector of any identified training needs. Individual training records were provided to the inspector for 19 staff and four relief staff who worked in this designated centre. These were reviewed regarding areas identified as mandatory in the regulations. The inspector's findings indicated that as well as there being greater oversight of staff training in one house, significantly more staff working in that house had up-to-date training. Records indicated that only one of the ten staff in one house had recently completed training in fire safety, and that half of this staff team required training in behaviour that is challenging including de-escalation and intervention techniques. One staff member also required refresher training in safeguarding vulnerable adults. Other training needs related to infection prevention and control (IPC), including the use of personal protective equipment (PPE). Training gaps in fire safety and hand hygiene were identified for some relief staff.

Planned and actual staff rotas were available in the centre. The inspector reviewed

these for one house only. From a review, the inspector assessed the staffing was routinely provided in the centre in line with the staffing levels outlined in the statement of purpose. Rotas indicated that residents received continuity of care from a core staff team.

Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities

The registered provider had paid the annual fee outlined in this regulation.

Judgment: Compliant

Regulation 15: Staffing

The number and skill mix of staff was consistent with what was outlined in the statement of purpose of the designated centre. Residents received continuity of care and support from a consistent staff team. Staff personnel files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were identified as requiring training in fire safety, the management of behaviour that is challenging including de-escalation and intervention techniques, safeguarding, and infection prevention and control.

Judgment: Not compliant

Regulation 23: Governance and management

The management and oversight systems in place required improvement to ensure that the service provided is safe, appropriate to residents' needs, consistent, and effectively monitored. There was inadequate implementation and oversight of documented quality improvement actions. Although plans were put in place, they were not consistently implemented. It was assessed in 2019 that the centre was not appropriate to meet one resident's needs. This resident's transition plan had abruptly stopped in September 2021, with no documented progress since. Oversight systems in place were not always effective, for example, although infection

prevention and control (IPC) audits were completed regularly in each house, these had not identified and highlighted the damaged surfaces throughout the centre. There was insufficient oversight of staff training in one house. The limited access to transport for the residents of one house indicated that the centre was not adequately resourced. Improvement was required to ensure that the provider's policies, including the one regarding medication management, were implemented as outlined. Medication management audits had not taken place in the centre at the frequency outlined in the provider's policies and procedures. Improvement was also required in the recognition of all restrictive practices used in the centre and the documentation regarding complaints.

Judgment: Not compliant

Regulation 34: Complaints procedure

One complaint was recorded in the centre since the last inspection completed on behalf of the Chief Inspector. The record of complaints did not include details of the investigation into this complaint, the outcome, any action taken on foot of the complaint, and whether the resident was satisfied. The inspector received assurances during the inspection that this had been addressed in a timely manner to the satisfaction of the complainant. The finding that complaints were not made, as agreed, on residents' behalf is referenced under Regulation 9.

Judgment: Substantially compliant

Quality and safety

It was clear that residents enjoyed living in this centre and were supported by staff who involved them in the running of their homes, and encouraged their participation in day-to-day, and preferred, activities. However, one resident continued to live in the centre despite a 2019 assessment indicating the arrangements in this centre did not meet their needs. Other areas requiring improvement were identified. Most notably, significant improvement was required in the implementation of the provider's medication management policy.

Residents living in the centre enjoyed participating in a variety of activities. Two residents had recently enjoyed attending a concert in Cork City. One resident had visited an elderly relative the previous weekend. Another had recently been able to increase the number of days a week they went swimming, an activity they really enjoyed. The inspector was told that some residents had participated in a community run with support from their day service. Residents went on day trips and some had gone to a neighbouring county for a weekend break. It was noted that

residents living in one house participated in more on-campus and in-house activities than the other. In-house activities included listening to music and having a foot massage. Some residents' faith was important to them. Staff supported them to attend Mass on the campus regularly and they also chose to watch services at times on the television. Others loved music and used the televisions in their room to watch concerts. Residents were also involved in some of the day-to-day activities in the houses such as meal preparation, recycling, and getting the post from the main office on the campus.

Residents' meetings took place monthly in both houses. These meetings facilitated staff to consult with residents about the running of the centre. Topics such as complaints, infection control practices, and fire drills were regularly discussed. These meetings were used to plan meals and activities. There was reference to several Christmas related activities that staff had supported residents to be involved in. These included shopping for presents, watching Christmas films, decorating their homes, and visiting a Christmas fair in Cork City.

Contact with family was important to the residents living in the centre and this was supported by the staff team. Relatives were welcome in the centre and staff also supported residents to visit their family members. It was explained to the inspector, that some residents had increased their level of family contact during and since the COVID-19 pandemic. When in-person visits were not possible, staff had made concerted efforts to maintain important relationships by regularly sending cards, photographs, and other items. Phone calls and the use of teleconferencing had also increased. It was reported that the use of technology had been challenging and confusing for some residents. Since visiting restrictions had eased, residents had returned to spending time in their relatives' company. Residents had recently celebrated milestone birthdays and two residents had attended family weddings in the previous 12 months.

In one house, the main meal of the day was delivered from the provider's main canteen located on the campus from Monday to Friday. At the weekends, pre-prepared meals were ordered from a delicatessen. Staff advised that meal choices were available to residents and that staff made any required changes to the texture or consistency of the meals, in line with residents' assessed needs. Staff spoken with had a good knowledge of these needs and copies of residents' plans were available in the kitchen, for easy access. In the other house in the centre, the inspector was informed that all meals were cooked and prepared by the staff team. When asked why this practice was not consistent across the centre, the inspector was informed that due to the number of residents, their assessed needs, and the staffing ratios in place in one house it would be a challenge to cook all meals every day. At the feedback to this inspection, management advised that there would be additional staff allocated to work with four of these residents following their move to a house in the community.

The inspector reviewed a sample of the residents' assessments and personal plans. These provided guidance on the support to be provided to residents. Information was available regarding residents' interests, likes and dislikes, the important people in their lives, and daily support needs including communication abilities and

preferences, personal care, healthcare and other person-specific needs such as mealtime support plans. When looking at the documents included in residents' personal plans it was noted that some, for example residents' individual response plans, had not been reviewed in the previous 12 months. Residents had recently updated communication passports which outlined residents' communication styles, needs and preferences. Some also had personal communication dictionaries which documented how residents used body language to communicate with others. A multidisciplinary review of each plan had been completed in the last 12 months, as is required by the regulations.

Residents' healthcare needs were well met in the centre. Residents had an annual healthcare assessment. In general, where a healthcare need had been identified a corresponding healthcare plan was in place. However, the inspector did identify some instances where these were not in place. There was evidence of input from, and regular appointments with, medical practitioners including a number of specialist consultants. There was also evidence of input from other health and social care professionals such as speech and language therapists, and occupational therapists.

Residents' personal plans also included plans to maximise their personal development in accordance with their wishes, as is required by the regulations. Personal development goals outlined what each resident wanted to achieve in the year. These goals were personal to the residents and reflected their interests and what was important to them. The review of residents' goals was inconsistent across the designated centre. Although there was evidence of regular review, for some residents it was not always possible to determine what, if any, progress had been made in achieving these goals. It was also noted that some goals were reviewed more regularly than others. For other residents, progress regarding each goal was clearly documented on every occasion.

As outlined in the opening section of this report, poor practices regarding the storage of resident's medicines were identified by the inspector in one house. In the other house, the inspector reviewed the medication management processes in place with a staff member. This staff member was familiar with the systems in place. In both houses medicines were stored in a secure, designated area. Each resident's medicines were stored separately from those belonging to their peers. A small medication refrigerator was available in both houses. This was in use in one, and not in the other. It was not possible to lock either fridge. This was also a finding of an unannounced visit completed by the provider in June 2022.

The inspector looked at one resident's medicines. It was noted that the date that one topical medicine had been opened was not recorded. Another had not been closed properly. The directions on the label of another medicine had been crossed out in pen. It was not clear who had done this. These practices were not in keeping with the provider's own medication management policy and procedures. Residents' prescriptions had been recently reviewed and an up-to-date signature bank of staff who administered medicines was available. When reviewing a resident's prescription it was noted that the maximum dose to be administered within 24 hours of PRN medicines (those administered as the need arises) was not always noted. This was a

requirement of the provider's policy. It was also noted that one administration protocol referenced the generic names of a resident's medicines, however these names were not used or referenced on the resident's prescription. This could be confusing for staff.

The inspector was informed that typically the pharmacy provided the centre with a one month supply of each resident's medicines. The inspector asked staff to guide them through the process to be followed on receipt of these medicines. In the course of this, it was identified that staff checked the contents of the delivery against the labels on the medicines, rather than the residents' prescriptions. This was not in keeping with the provider's policy and did not safeguard against any possible errors made on the labels. As has been identified recently in other centre's operated by this provider, the inspector concluded that the oversight and implementation of the provider's medication management policy required significant improvement.

Although the centre was generally clean, some areas had been overlooked or were identified as requiring additional cleaning. These included couches in one living room, kitchen bins, and areas in the living rooms and bathrooms where cobwebs were seen. A colour coded cleaning system was in place where different coloured equipment was to be used to clean specific areas of the centre so as to prevent cross contamination. Information was on display regarding this system. A number of damaged surfaces were observed in both houses, including in the apartment area. These included a mat in the relaxation room, the kitchen floor and units in one house, dining chairs, and furniture in the staff office and in the apartment living room. Monthly infection prevention and control (IPC) audits were completed in both houses in the centre. The inspector looked at records relating to one house. It was evident that these matters had not been identified in these audits. They were also not referenced in the assessment completed in January 2023 to provide assurance of the centre's preparedness planning and IPC measures. Records indicated that all staff had completed some training in IPC. Contingency plans to be implemented in the event of a suspected or confirmed case of COVID-19 or any other transmissible infection were in place. However, these required a review and update to reflect changes made to public health and the provider's guidance since the plans were developed in May 2022.

Systems were in place and effective for the maintenance of the fire detection and alarm system, fire fighting equipment, and emergency lighting. Each resident had a recently reviewed personal emergency evacuation plan (PEEP) to be implemented if required. Regular drills were taking place and were completed within timeframes assessed as safe by the provider. The provider had a protocol in place where staff working in other houses would come to the houses to provide assistance to evacuate either or both houses at night. Although a recent drill had been completed with night-time staffing levels, none of the residents were in bed at this time. The provider committed to completing a drill in this scenario to assure themselves that the centre could be safely evacuated at all times. It was also planned to include the location of the simulated fire in future drills so that staff and residents would be familiar using all evacuation routes. When in one house, it was noted that a door between the kitchen and a communal area was damaged. This required review by a

competent person to ensure that, if required in the event of a fire, it would serve as an effective containment measure.

In December 2022, lightning damaged three fire panels on this campus, including those installed in this designated centre. This was not the first time this had occurred. Additional, temporary precautions had been put in place, including the provision of battery operated alarms and increased staff monitoring by night, while these fire panels were being restored. Since then, additional works had been completed to prevent a similar event from occurring again.

Regulation 10: Communication

Residents were supported to communicate in line with their needs and wishes. Staff had a very good knowledge and awareness of residents' individual communication needs. Visual supports were on display through the centre to support communication. The inspector also observed the use of objects of reference. Residents' had access to media including televisions, radio and the internet.

Judgment: Compliant

Regulation 11: Visits

Residents were supported to receive visitors in the centre in line with their wishes. However, most chose to spend time with families and friends outside the designated centre.

Judgment: Compliant

Regulation 13: General welfare and development

Residents were supported to attend day services in line with their own preferences. Residents had access and opportunities to engage in activities in line with their preferences, interests, and wishes. The opportunities for community-based activities were limited for residents in one house by the limited access to transport.

Judgment: Substantially compliant

Regulation 17: Premises

Overall, the centre was observed to be clean. However, areas that required additional cleaning were identified in both houses. Repair and maintenance were required in the designated centre to ensure that it was kept in a good state of repair

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Food choices were offered at mealtimes. Staff spoken with had a good knowledge of residents' individual dietary needs. Residents' participated in food preparation in line with their wishes. Preparing a preferred snack was a current goal for many residents.

Judgment: Compliant

Regulation 27: Protection against infection

Procedures had been adopted to ensure the residents were protected from healthcare-associated infections including COVID-19. Personal protective equipment was available and in use and all staff had completed some training in infection prevention and control (IPC). The centre was generally clean although some areas had been overlooked. A COVID-19 contingency and isolation plan specific to each house of the centre was in place. These required review to reflect recent changes to the provider's and other national guidelines. There were many damaged surfaces evident throughout the centre which therefore could not be cleaned effectively.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire safety systems in place in this designated centre included fire alarms, emergency lighting and fire fighting equipment. Fire drills were taking place regularly. None had taken place in night time conditions with minimum staffing levels and residents in their beds. Management committed to addressing this. One door to a high risk area required review by a competent person to ensure that it would still function as an effective containment measure, if required in the event of a fire.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The provider had practices in place relating to the ordering, prescribing, storage, disposal and administration of medicines in the centre. Improvement was required to ensure that these practices were implemented consistently in the centre. Areas requiring improvement included the process to be followed on receipt of medicines from the pharmacy, the secure storage of all medicines, and the storage and labelling of medicines. When reviewing a prescription for PRN medicines (medicines only taken as the need arises), it was noted that the maximum dose to be administered in 24 hours was not always documented. These identified poor practices increased the risk of medication errors in the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

An assessment of the health, personal, and social care needs had been completed for each resident. A comprehensive personal plan was in place. An annual review of residents' personal plans, involving multidisciplinary professionals, had taken place. Not all identified healthcare needs, had a corresponding support plan in place, and not all elements of residents' plans had been reviewed in the previous 12 months. While there was evidence of some very good practice in supporting residents to achieve their personal development goals, the review of goals was not consistent across the centre.

It was assessed in 2019 that the arrangements in the centre did not meet the needs of one resident. At the time of this inspection, this resident continued to live in the centre with no agreed plan in place for them to move.

Judgment: Not compliant

Regulation 6: Health care

Residents' healthcare needs were well met in the centre. Residents had access to medical practitioners, and other health and social care professionals as required. The finding that not all identified healthcare needs had a corresponding plan is addressed in Regulation 5.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required one had a behaviour support plan in place. These outlined proactive approaches to prevent or reduce the likelihood of an incident occurring, and also response plans to be implemented if required. Staff had a good awareness of these plans and were observed implementing them during the inspection. Not all restrictive practices used in the centre had been identified, and had therefore not been subjected to the provider's own policy.

Judgment: Substantially compliant

Regulation 8: Protection

There were no active safeguarding plans in the centre at the time of this inspection. There were recently reviewed, personalised intimate and personal care plans in place. The majority of staff had attended training in relation to safeguarding residents and the prevention, detection and response to abuse. Identified training gaps are reflected in the findings regarding Regulation 16.

Judgment: Compliant

Regulation 9: Residents' rights

Day-to-day supports were provided in a manner that respected residents' rights. Residents' meetings were held regularly in the centre. It was identified that agreed actions to make complaints on residents' behalf regarding ongoing inappropriate placements and limited access to transport had not been made.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for No 2 Seaholly OSV-0004572

Inspection ID: MON-0038390

Date of inspection: 07/03/2023

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The person in Charge will ensure staff have access to appropriate training including refresher training as part of a continuous professional development programme. • The Person in Charge will ensure specific training requirements to meet the needs of the residents are identified and planned for. This will include planning for training requirement identified during staff supervision sessions and chairing a meeting annually, or more often if required to identify any change in need for the persons residing there. The Annual Multi-Disciplinary Review of the Personal Plan will support this process. • The Person in Charge will notify any trainings identified as required to the training Department for planning and delivery and will ensure that the Training Matrix log is kept updated. • The person in Charge will ensure online training certificates are sent to the training department to ensure the matrix is updated as trainings are completed. • All staff members will have completed trainings in Fire safety, Crisis prevention intervention including de-escalation techniques, safeguarding and infection prevention & control training including hand hygiene and use of PPE by 4th May 2023	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The registered provider will ensure the designated Centre is resourced to effective delivery of care and support in accordance with the Statement of Purpose by continuing to monitor the effectiveness of its defined Management structure and that the Person in Charge attends all Annual Multi-Disciplinary Review Meetings, restrictive practice sanctioning and review meetings. The Provider will ensure the following specific areas are improved • Ensure that there is a regular review of practices to ensure that all restrictions are	

notified to the authority and process in line with Provider policy, including the storage of kitchen shape items
• The Person in Charge will ensure online training certificates are sent to the training department and that the Training matrix is updated for all houses as trainings are completed.
• The complaints log of the Centre is reviewed on a regular basis to ensure all issues are acted on appropriately and fully documented.
• Monthly infection control audits are completed and include all maintenance requests are followed up on a timely basis
• All alternative placements are fully explored for inappropriate placements through the Provider in-house systems by 30.04.2023 with a view for the placement to be resolved by 30.09.2023
• All actions arising from provider 6 monthly visits will be monitored to ensure completion and specific focs will be given to medication management practices, maintenace and staff training.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The registered provider has ensured there is an accessible, age appropriate complaints procedure in place. The complaints procedure is displayed in the designated Centre.
• One complaint recorded had been resolved via email in December 2022, this resolve had not then been documented in the complaints folder, and this documentation was completed on 07.03.23.
• Complaints regarding access to transport and living arrangements for one person supported were generated in August 2022. This information was not included on the house complaint log, this was completed on 23.03.23.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• The registered provider ensures each person supported has opportunities to participate in activities in accordance with their interests, capacities and development needs.
• Persons supported are supported to maintain personal relationships with family and friends.
• Funding for increased access to transport has been requested and will be in place by 30.06.23

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The registered provider has ensured that both premises are laid out to meet the needs of the residents living there.
• All residents have individual and age appropriate sleeping accommodation.
• A new sofa for 1 apartment and 2 dining room chairs were ordered on 20/03/23
• Funding was approved to upgrade 1 kitchen on 21.03.23 and works will be completed by 30.06.23
• The kitchen in the 2nd property will be replaced by 31.05.23

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection: The Provider will ensure that • The local contingency plans were updated on the 13.03.23 • The Provider IPC Self-Assessment Tool was updated January 2023 and will be reviewed on 3rd April 2023. • Monthly infection control audits will identify all areas of non-compliance including staff training and damaged surfaces and ensure that appropriate action is put in place to remedy issues identified • Staff training on IPC including use of PPE and hand hygiene will be updated as necessary • Cleaning schedules are kept under review for completeness to ensure areas are not overlooked

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • The designated Centre takes adequate precautions against the risk of fire including suitable firefighting equipment, building services, bedding and furnishings. • A competent person reviewed 1 door in a property on 28.03.23 and assurances have been provided it would still as an effective containment measure in the event of a fire. • Fire drills had been completed at night however residents were sitting in the living area of the property, a drill is scheduled for 23.03.23 to evacuate residents from their bedrooms. Drills will detail where in the property the fire was for the purposes of the drill.	
Regulation 29: Medicines and pharmaceutical services	Not Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: The Provider will ensure that • Delivery of Medication – To ensure the delivery is that of prescribed medications the Person in Charge will ensure that staff check the delivery of the medication against the residents' prescription not the labels of the medications delivery. • Medications are held securely stored in a locked cabinet or fridge as appropriate in the Centre 15.03.23. • All topical medication tubes are closed properly when stored • Medication is properly labelled - One medication without a label was disposed on the day of inspection via return to the pharmacy. - dates of opening topical medication will be recorded - directions for use of medications will be clearly legible - staff will be supported to ensure that the Medication administration Protocol and the residents prescription use the same medication names – generic or brand – to avoid confusion • All empty PRN medication boxes are disposed of immediately on use • All PRN medications have maximum dosage identified - A meeting was held with the services General Practitioner on 15.03.23 all medication charts were reviewed and max dosage in 24 hours was included.	
Regulation 5: Individual assessment and personal plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual	

assessment and personal plan:
• The person in charge has ensured that a comprehensive assessment of health, personal and social care needs of each resident has been carried out.
• Steps taken to address one residents assessed needs not being fully addressed in the Centre are being reactivated and the Provider admissions, discharge and transfers committee were engaged to support in finding a resolution guided by Multi-Disciplinary team members recommendation as to what this persons needs were in regards to environment.
• This person has been supported by a familiar staff team in the interim by making minor alterations to the existing property and to daily routines to support this person's need for space and quiet.
• The person in charge has identified 3 possible vacancy's that may be suitable for this person. The Social Care leader will be visiting these properties on 20.04.23. If a vacancy is deemed to be suitable the process would involve the admissions, discharge and transfers committee approving same followed by compatibility assessments and transition planning. This matter is targeted to be resolved by 30.09.2023

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• The registered provider ensures that where restrictive procedures are used such procedures are applied in accordance with national policy.
• Sharp utensils that were stored in a locked press were removed on the day of inspection 07.03.23
Staff Training in supporting residents with behaviours of concern including crisis prevention and de-escalation techniques will be completed as necessary

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Complaints regarding access to transport and living arrangements for one person supported were generated in August 2022. This information was not included on the house complaint log, this was completed on 23.03.23.

• Funding for increased access to transport has been requested and will be in place by 30.06.23

• Progression of inappropriate placement resolution will be continued to be monitored by the Provider ADT Committee for resolution by 30.09.2023

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(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.	Substantially Compliant	Yellow	30/06/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	04/05/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Substantially Compliant	Yellow	30/06/2023

	state of repair externally and internally.			
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.	Substantially Compliant	Yellow	30/04/2023
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	30/09/2023
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 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	Not Compliant	Orange	20/04/2023

	put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	03/04/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	28/03/2023
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.	Substantially Compliant	Yellow	23/03/2023
Regulation	The person in	Not Compliant		15/03/2023

29(4)(a)	charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.		Orange	
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	23/03/2023
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/09/2023
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident	Substantially Compliant	Yellow	30/04/2023

	is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).			
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	30/04/2023
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	07/03/2023
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the	Substantially Compliant	Yellow	30/09/2023

	freedom to exercise choice and control in his or her daily life.			