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:	Saoirse
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	11 August 2022
Centre ID:	OSV-0004767
Fieldwork ID:	MON-0031710

About the designated centre

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

This designated centre is based on a large campus setting within the environs of Limerick city. There has been a number of re-configurations of this designated centre in recent years. Currently the centre is comprised of three bungalows and is registered to support a maximum of 17 residents. Adults both male and female with a diagnosis of intellectual disability are supported in this designated centre. One bungalow can accommodate 5 residents. This bungalow consists of four individual apartments and one bedroom. Three of the apartments have access to communal dining and living areas. There is also a kitchen, staff office and staff room. The second bungalow is comprised of five bedrooms, one of which has an en-suite, another has a small sitting room area, a kitchen, dining room and two large sitting room areas. This bungalow also has staff office, bathroom and toilet facilities. There is also an enclosed garden area and an adjoining apartment with a sitting room, bedroom and wheelchair accessible en-suite. The third bungalow has six individual bedrooms, a kitchen, dining room, sitting room, two bathrooms and additional toilet area, utility and staff office. There is also an enclosed garden area with parking at the front of the property.

Residents are supported by a staff team comprised of nurses and health care assistants by day and night. Residents can avail of the on-site services such as day services, swimming pool, gym, church and multidisciplinary team support.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 11 August 2022	09:30hrs to 18:00hrs	Elaine McKeown	Lead
Thursday 11 August 2022	09:30hrs to 18:00hrs	Conor Dennehy	Support

What residents told us and what inspectors observed

On the day of the inspection, the inspectors had the opportunity to meet twelve of the residents living in the designated centre. The inspectors were introduced to the residents at times during the day that fitted in with their daily routine while adhering to public health guidelines and wearing personal protective equipment (PPE). This was an unannounced inspection to monitor the provider's compliance with the regulations and to follow up on the provider's progress with actions from previous inspections that were carried out in July and August 2020. In addition, to ensuring residents were being supported to have a good quality of life and in line with their assessed needs.

The inspectors visited all three houses in this designated centre. Each inspector visited one house during the morning and both inspectors visited the third house in the afternoon. Inspectors observed some variance in the designated centre relating to staffing resources which impacted the ability of some residents to engage in meaningful activities. In addition, inspectors also noted that issues relating to premises during the inspection had not been identified by the governance and oversight systems in place at the time of this inspection. This included the provider's unannounced audits and monthly infection prevention and control, (IPC) audits. There was also variance evident during the inspection in other aspects of support provided to residents in the designated centre. This included a lack of adequate space in one house to support ease of movement and communal space to meet visitors. Access and engagement in community activities was also inconsistent or limited for some residents.

While some residents in the designated centre did not directly interact with the inspectors, others expressed to staff that they would like to meet the inspectors. One resident told an inspector that they had spoken to a family member on the phone and would be seeing them during a planned visit home the week following this inspection. Another resident spoke of how they had been in the centre for 30 years and liked living there. This resident also showed an inspector their personal plan and a badge that they had received to mark a recent birthday. Another resident met with an inspector in their apartment as per their expressed wishes. The resident phoned a staff member to let them know that they were ready to meet the inspector. A familiar staff member was also present. The resident demonstrated during the conversation that they were fully informed about a planned procedure scheduled for September 2022. They outlined why they needed to have the operation and how the medical team had taken time to explain what was going to happen while they would be staying in hospital. The resident also spoke of their regular activities which included walks and swimming with staff, outings to local community amenities including shops and a public house. They outlined how they liked to go shopping for clothes and do their weekly grocery shopping in a particular shop. They spoke of how they had enjoyed attending concerts in a number of different locations, which included an artist the resident liked to listen too while relaxing in their home. The resident also spoke of their aspiration to get a job. The

staff member present assisted the resident to further explain this aspiration and was observed to offer multiple options to assist the resident achieve a suitable outcome.

Inspectors' engagement with other residents varied and reflected individual preferences. For example, one resident liked to have paper or a book and enjoyed taking these items from staff regularly as part of their interactions with others. A staff member provided an inspector with a blank notepad and while the inspector was talking to the resident, the notepad was removed from the inspector's hands by the smiling resident. Staff explained this appeared to provide enjoyment to the resident who proceeded to self-propel their wheelchair to leave the office area after attaining the notepad. Another resident was introduced to an inspector in a communal sitting room. This resident enjoyed calling the inspector by their name throughout the morning. They appeared to enjoy asking the inspector to assist them with music choices and conversing about their upcoming plans to visit family members. The staff encouraged the resident to explain what activities they liked to do which included playing ball outside in a garden area, attending music sessions and art. The staff also encouraged the resident to talk about a recent visit to a beach in the days prior to the inspection. The resident had a visit from a family representative during the morning of the inspection and was able to enjoy the privacy of their personal outdoor space to talk with their relative.

Inspectors were informed that four of residents had attended a social gathering in the campus hub earlier that morning to mark the retirement of a staff member from another location on the campus. A resident had gone shopping with a staff member during the morning, which staff outlined to an inspector how much they had enjoyed purchasing specific items. In addition, staff were observed talking with residents planning to go to the cinema later on in the day. One resident who had recently moved into a self-contained apartment attached to one of the houses responded with gestures to a familiar staff indicating that they were happy when an inspector visited them. The staff member outlined the positive impact this move had on the resident which included a reduction in their anxiety levels and facilitated the resident to engage with the staff team and peers as they choose to.

All staff were observed and overheard to be respectful and attentive towards the residents throughout the inspection. For example, given the weather on the day of inspection staff members were noted to be mindful to ensure that residents had sun cream on and that residents wore hats. Staff spoken to during the inspection outlined to the inspectors some of the activities which a number of the residents had participated in. For example, residents enjoyed boating experiences on a lough, local sporting events, visiting local pet farms, beaches and attending concerts. There were also plans to take residents on overnight short breaks and attend a concert in the months after this inspection.

However, it was evident during the inspection that a lot of staff time in one house was taken up supporting residents with personal care particularly for two residents. Both of whom required the support of the two staff members on duty with some activities of daily living, (ADLs). This was noted to reduce the potential for other residents in the unit to be engaged in meaningful activities. While some residents were seen to go for independent walks on the campus where this centre was

located, other residents were seen to spend the majority of their time sitting down on seats or laying on their beds while the inspector was present. The inspectors acknowledge that these residents did appear content at these times. The person in charge outlined that additional staff resources were usually provided in the designated centre, in particular to one of the houses but were not present on the day of inspection due to annual leave. The day service staff and other resources available through community employment schemes were not replaced during planned or unplanned leave and this impacted directly on the resources available to support residents during these periods in the designated centre.

Throughout the inspection, the inspectors observed evidence of deterioration with the premises and some furniture in the designated centre. For example, ovens in all three houses had grease build-up evident. There were a number of locations throughout the designated centre that had damaged and worn flooring. There were damaged surface areas including on dining tables which impacted effective cleaning processes. A number of doors and door frames were damaged and marked. Kitchen units which had chipped surfaces, some of which had evidence of extensive damage. For example, underneath a refrigerator in one house, the wood appeared to be rotting. There was perspex on windows with a number of these, including the windows in some resident bedrooms, visibly unclean, stained, opaque and streaky in appearance. Limescale build -up was evident on a number of water taps and rust was evident on a number of bathroom fittings. The bathroom and toilet areas for residents were noticeably of poor standard in their layout, general appearance and cleanliness. Examples of this included stained floors, worn taps and a grab rail that was significantly rusted. Parts of a sluice room which lead directly to one bathroom were seen to require further cleaning.

Some residents who required the use of mobility aids were observed to be impacted by the limited space available to them in one of the houses. An inspector observed one resident being supported to leave their bedroom in a wheelchair and it was noted that it was a tight fit for the wheelchair to pass through the bedroom door with one wheel of the wheelchair seen to clip off the door frame. The overall size of the building was relatively small particularly given that five residents were living there at the time of inspection. In particular, it was observed that the hall area was narrow. Internal communal space was limited but an enclosed garden was available to the rear of the building which did have some garden furniture and a sound system present with some residents seen to use this during the inspection. In addition, following a review of relevant documentation, some residents received their visitors in their bedroom as the particular building had no other indoor space for residents to receive visitors in private.

The inspectors were aware of the planned transition of one resident to another designated centre in advance of this inspection. This was reported by staff to have been completed successfully and the resident was enjoying their new home. Another resident was spending time at home with relatives at the time of this inspection. Staff outlined the medical input required by this resident and how the resident was supported by the staff team to have their day service from the designated centre. In addition, staff explained the resident usually stayed in the designated centre two nights each week. However, they could access the designated centre at any time in

line with their wishes.

The next two sections of this report will present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how

Capacity and capability

Overall, the inspectors found that improvements were required to the monitoring systems in operation for the centre to ensure consistent, safe and person-centred services for all residents living in this designated centre.

This designated centre was based on a campus and had first been inspected by the Health Information and Quality Authority (HIQA) in October 2014. Six inspections between then and August 2020 had highlighted recurrent concerns around the standard of premises provided and fire safety. One of the buildings which made up this designated centre had previously been the subject of a restrictive condition which required the provider to the upgrade the building by 31 January 2020 but the standard of this building continued to require improvement after this date. Significant regulatory engagement, which included the issuing of a warning letter in September 2020, resulted in this designated centre's registration being renewed until January 2024 with a further restrictive condition which reflected a plan to improve the fire safety systems across the overall campus including this centre. The plan which informed the restrictive condition had a final date of May 2023 and outlined specific dates when fire safety upgrades were to be carried out across the campus.

In line with this plan two of the three building which made up this centre were due to have been upgraded for fire safety by January 2022 and June 2022 respectively with the third building to close by July 2022. However, throughout 2021 it was evident that such time frames would not be met with resourcing of the overall plan a particular issue. In further engagement with HIQA during 2021 and 2022, the provider had put forward an alternative plan for consideration which involved two buildings of this centre being upgraded and the remaining building being closed by the end of 2024. The provider though had been unable to provide sufficient assurance as to how such alternative plans would be fully resourced. Given that the regulations require registered providers to ensure that designated centres are appropriately resourced, and taking into account extensive engagement between HIQA and the provider concerning the campus, the provider was advised during a cautionary meeting with HIQA in May 2022 of the consequences of continued non-compliance with registration conditions and relevant regulations.

It was found on this HIQA inspection that the provider had not demonstrated progress relating to improvements in the premises and fire safety upgrade works in this designated centre. In addition, some audits being completed were ineffective in identifying issues. In particular, monthly IPC audits. Inspectors reviewed a sample of

these IPC audits that were carried out individually for each of the three buildings of this centre. It was noted that these consistently indicated a high level of compliance in IPC matters such as cleanliness but this was inconsistent with the observations of inspectors during this HIQA inspection as referenced elsewhere in this report.

The provider had completed key regulatory requirements such as provider unannounced visits and annual reviews. While actions had been identified, the progress of some actions were not consistently updated or documented within the time lines outlined. Amongst the areas reviewed included staffing. The residents were supported by a staff team which was comprised of both nursing and social care. There were a large number of core staff with regular relief staff also available. Following review, it was found that staff rosters were being maintained while records provided indicated that staff members had completed relevant training to ensure that they were equipped with the necessary skills and knowledge to support residents. However, the impact of planned annual leave and other staff absences directly impacted on the resources available to support residents to engage consistently in meaningful activities, as found on the day of this inspection. This was not in line with the statement of purpose for this designated centre.

Following a review of the floor plans for all three houses and inspectors completing a walk around of each house, the layout of two of the three buildings of this centre did not reflect the statement of purpose and floor plans that the centre had been most recently registered against. This was despite a HIQA inspection conducted in May 2022 highlighting a similar issue for another designated centre on the same campus.

Registration Regulation 8 (1)

The provider had completed refurbishment works in two of the houses which involved changes to the layout of these buildings with a change of use to some areas. The provider had not applied to vary the registration conditions of this centre to reflect these changes as seen by both inspectors at the time of this inspection.

Judgment: Not compliant

Regulation 14: Persons in charge

The person in charge worked full time and their remit was over this designated centre only. They were aware of their role and responsibilities and were supported in their role by clinical nurse managers.

Judgment: Compliant

Regulation 15: Staffing

Residents were supported by a team of staff with a skill mix of qualifications both by day and night. There was an actual and planned rota in place which reflected the staffing resources on duty on the day of this inspection. There was a large core group of staff with additional regular relief staff available who were familiar to the residents. However, at the time of the inspection the resources available to support the residents was limited which directly impacted on the ability of some residents to engage in meaningful activities at times during the day. The availability of these resources had also been identified as an ongoing issue during other periods of planned or unplanned absences in the designated centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had ensured all staff had completed up-to-date training and refresher courses required to support the assessed needs of the residents in this designated centre. This included fire safety, infection prevention and control (IPC) and safeguarding. In addition, scheduled training for 2022 had been booked for staff in advance of their current training expiring. All staff were also supported to attend regular supervision in this designated centre.

Judgment: Compliant

Regulation 23: Governance and management

The provider had not offered sufficient assurance that they had the necessary resources in place to comply fully with this designated centre's current restrictive condition. In addition, systems in place at the time of this inspection did not provide adequate assurance that the provision of services were being effectively monitored and consistent. This was also an action in the previous inspection of August 2020. Staff meetings were not taking place in the designated centre with no evidence documented that staff were informed of up-to-date information or changes pertaining to the designated centre in the communication handover that was being used in the designated centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

The provider had ensured a statement of purpose was in place for this designated centre and had been subject to review. However, the floor plans as outlined in the current document did not accurately reflect the actual premises in two of the houses at the time of this inspection.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

On review of the incident log for this designated centre since January 2022, the person in charge had notified to the Chief Inspector all notifications as required by the regulations.

Judgment: Compliant

Quality and safety

Overall, the maintenance and upkeep of the premises required review. The findings of this inspection found evidence of ongoing issues that had been identified in previous inspections of this designated centre in July and August 2020 which included fire safety upgrade works and premises. The provision of appropriate fire containment measures remained outstanding at the time of this inspection. Improvement was also identified regarding aspects of personal planning, health care and infection prevention and control practices.

All residents had personal plans in place. Inspectors reviewed a sample of these plans and noted that they generally contained a good level of information on how to support residents and were subject to multidisciplinary review. However, for one resident it was seen that their personal plan did not contain specific information on how to communicate with the resident. A process of person-centred planning was being followed to ensure that residents and their families were involved in the review of these personal plans and also to help identify specific goals for residents to achieve, such as attending concerts. However, it was noted that some residents' personal planning processes were overdue.

As previously mentioned, inspectors were informed of a number of social activities

some residents had been supported to participate in. However, some variance was evident following a review of regular activities for other residents. Some residents frequently engaged in campus based activities such as walks and listening to music with limited community based activities. Some of these residents had activities listed such as going for drives but it was unclear if the residents had gotten out of the vehicles used at any point during these drives. Some other activities listed included pet therapy and art therapy but for one resident, a physiotherapist review was indicated as being an activity they participated in. While some goals identified for one resident did not document when they were to be achieved or who was responsible to support the residents with these. The person in charge and staff team outlined during the inspection how due to the pandemic the provision of day services/activation for some residents from their homes had positively impacted their lives, with improved flexibility in daily routines. Some residents attended a day service on the campus a few days each week. The person in charge had also relocated additional staffing resources to one of the houses, but these resources were not replaced when on leave. As already mentioned in this report, this was found to be the situation on the day of the inspection.

Residents' also had health care plans which included guidance for staff on how to support residents with any healthcare issues that they had. Records reviewed also indicated that residents were supported to access various health and social care professionals when required such as general practitioners and physiotherapists. However, when reviewing health records for one resident with diabetes, it was seen that the last record of this resident having taken part in a national diabetic retina screening program was from March 2017. This is a screening program which is available once a year with the resident's diabetes care plan, most recently reviewed in May 2022, indicating that all such screenings were to be done. This was highlighted to management of the centre and a hand written entry in the resident's personal plan was later shown to an inspector which suggested that the resident may have had a diabetic retina screening in February 2019 but that there was no record to definitively confirm this and there was no record of any other such screening for the resident available since then. Records were provided for other residents who were eligible to receive other health screening services which showed that they had undergone such screenings in a timely manner.

Inspectors also reviewed records related to fire safety in this centre. There were day and night fire checklists in place for staff to complete. In addition, fire marshals were identified for each shift, with an alert system in place through the phones which were observed to be in the possession of the nominated staff during the inspection. The records of fire drills reviewed, indicated that fire drills were being carried out regularly with low evacuation times recorded. It was noted that records of such fire drills did not outline any particular escape routes during these drills while in one building it was seen that a copy of a fire evacuations procedures for that building were accompanied by floor plans which did not reflect the actual layout of the building. Residents did have personal emergency evacuation plans (PEEPs) in place which had been recently reviewed and outlined the supports residents needed to evacuate. However, the evacuation procedures when one resident was in bed did not reflect the evacuation procedures that staff said would be followed for this resident, if required. Other records reviewed indicated that the fire safety systems in

place in the centre, such as fire alarms and emergency lighting, were being serviced at regular intervals to ensure that there were in proper working order.

As highlighted earlier in this report monthly IPC audits were being conducted in the designated centre which indicated a strong level of compliance. However, inspectors observed various areas where further cleaning was needed. The inspectors observed a number of gaps and inconsistencies in the IPC records while it was particularly noticeably that some areas which were indicated as being cleaned regularly in some records reviewed were visibly unclean on the day of inspection. In addition, contradictory signs were on display regarding particular colour coded cleaning equipment, such as mops, that were to be used in certain rooms. This was highlighted to management of the centre who indicated that some of the signage was out of date. While the most recent signage indicated the colour coding of equipment that was to be used in the kitchen area, this was not present in an area of the designated centre at the time of the inspection.

The assessment, management and ongoing review of all centre specific risks was not in place in this designated centre at the time of this inspection. For example,inspectors were informed that there were a number of water outlets that were not in regular use. This was also evident to the inspectors during the inspection. However, this was not identified as a risk in this designated centre. There was no procedure in place for staff to mitigate/reduce the risk of Legionnaires disease at the time of this inspection. Inspectors were informed during the feedback meeting by the person participating in management that while the risk of Legionnaires disease was identified on the provider’s overall risk register, this had not been identified as a risk in this centre. As a result no control measures or actions were in place to identify or reduce the risk of Legionnaires disease in this designated centre. In addition, inspectors were informed by staff they were not completing weekly flushing of unused/ or infrequently used water outlets in line with guidance in the national standards of IPC.

The inspectors were aware the staff team had supported residents who contracted COVID-19 at different times during 2022. One house was managed as an isolation unit to support all of the residents living there during July 2022, with clear guidelines for staff on protocols which included dedicated entry/exit points, donning and doffing stations/areas and avoiding cross over of staff from other houses which effectively reduced the transmission to other residents and staff members on the campus. Individual supports were provided for residents in another house in April 2022 which included transferring one resident to a dedicated isolation unit on the campus, providing information and support to another resident who was being supported at home by family representatives at the time and supporting another resident to self-isolate in their apartment. All those affected recovered from the illness.

Other issues identified by the inspectors included, a first aid kit contained some out of date of products. A recent audit indicated the first aid kit had been subject to inspection by auditors however, the expiry dates for some items were out of date for a prolonged period of time. For example, December 2021. While a fridge for storing medicines was unlocked when viewed by an inspector. Both of these issues

were highlighted to staff present who addressed both matters immediately.

All staff had attended safeguarding training and there were no active safeguarding concerns in the designated centre at the time of this inspection. The provider had ensured safeguarding concerns had been investigated in line with the provider's policy and procedures. Interim safeguarding plans that had been in place for five residents had been closed following an investigation. In addition, the relocation of two residents within the designated centre and campus had improved the quality of life for all of the residents within the designated centre. This included supporting residents to move to a different bedroom or move into their own apartment. However, the location of an external door from a sluice room in one house did not assure the inspectors that residents' privacy and dignity could be ensured at all times. There was no door between the bathroom area and the sluice room area. There was an external keypad for access on this door, so when the external door was opened from the outside, if a resident was being supported with personal care in the bath they would be visible to the person entering the area.

Regulation 10: Communication

While staff demonstrated their ability to effectively communicate with residents during the inspection; the specific information required to ensure effective communication for one resident was not available in their personal plan.

Judgment: Substantially compliant

Regulation 11: Visits

Residents were supported to receive and visit friends and family representatives. However, residents in one of the houses did not have a private space, which was not their bedroom to receive a visitor in their home if required.

Judgment: Substantially compliant

Regulation 13: General welfare and development

Instances such as physiotherapy review were being listed as activities that residents took part in. Some residents' ability to engage in meaningful activities were impacted when decreased resources were available.

Judgment: Substantially compliant

Regulation 17: Premises

All three buildings remained in a poor standard.

Judgment: Not compliant

Regulation 18: Food and nutrition

While residents were supported to have a varied diet as per their wishes, the storage of open food items with no label was seen on the day of the inspection in one house. An open jar was not labelled with a date of opening. This issue had been identified during a recent IPC audit in July 2022 with the actions taken documented which included, labels provided for staff to ensure all open perishable food stuffs were to have a label in line with safe food guidelines and the provider's protocols.

Judgment: Substantially compliant

Regulation 25: Temporary absence, transition and discharge of residents

The person in charge had ensured support was provided to a resident as they transitioned to another designated centre in a planned and safe manner. The resident was actively involved in the progress of the transition plan and supported by familiar staff.

Judgment: Compliant

Regulation 26: Risk management procedures

There was a centre specific risk register in place which was subject to regular review. However, not all centre specific risks had been identified for the designated centre, this included the risk of legionnaires disease and controls were not in place to reduce the risk of this occurring in the designated centre.

Judgment: Substantially compliant

Regulation 27: Protection against infection

While staff working in the designated centre with residents demonstrated good knowledge and adherence to IPC measures including appropriate wearing of PPE, not all visitors/external personnel were wearing face masks when inside the designated centre. Both inspectors observed staff not involved in the direct care of residents enter two different houses in the course of their duties without wearing a face mask. In addition, the effective cleaning of surfaces such as dining tables and the premises was negatively impacted due to damaged/incomplete or worn surfaces. In addition, some first aid supplies were noted to be expired since December 2021.

Judgment: Not compliant

Regulation 28: Fire precautions

Fire containment measures remained inadequate, the fire evacuation floor plans did not accurately reflect the actual layout of two of the houses. While fire drills were being completed including minimal staffing drills, scenarios using different exit points were not evidenced in the documentation reviewed. The documented evacuation plan for a resident if they were in bed did not correspond to staff knowledge at the time of the inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Residents had personal plans in place and evidence of residents actively being involved in the process was documented. Residents were supported to engage in regular community activities as well as activities on the campus when sufficient resources were available. However, not all plans had been subject to review within the previous 12 months and the progress of some goals had not been consistently documented as being reviewed or completed.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had care plans in place outlining how their health needs were to be supported. However, not all screening of chronic illness had been completed/documented for a resident.

Judgment: Substantially compliant

Regulation 8: Protection

No safeguarding concerns were identified during this inspection with all staff having undergone relevant training.

Judgment: Compliant

Regulation 9: Residents' rights

While all residents were supported in individual bedrooms, not all areas used to support private and intimate care ensured the privacy and dignity of residents. A bathroom area in one house had an external exit door with external keypad access in the small adjoining sluice area with no door in place between the two areas.

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 8 (1)	Not compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 11: Visits	Substantially compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	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	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Saoirse OSV-0004767

Inspection ID: MON-0031710

Date of inspection: 11/08/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Registration Regulation 8 (1)</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Registration Regulation 8 (1):
• Ashgrove 31 and Garden View floor plans updated
• Application to Vary sent to HIQA on the 26/08/2022</td></tr>
<tr><td>Regulation 15: Staffing</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
• One day service staff in place three days a week 09:30am to 16:30pm
• One CES staff in place five days a week 9am to 13:00pm
• Budget does not allow these staff to be replaced when on leave, SOP updated on the 13/09/2022 to reflect this.
• Roster Review of day service staff will take place by 31/10/2022 between all centers with a view to increasing day service support in this house to five days a week.
• The Services continue to actively recruit for staff but recruitment remains challenging which can have an impact of filling the residential roster.</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
• List of fire exits in each house now in place in each fire register
• Scenarios for Fire Drills remaining by day and by night for Q3 and Q4 completed by the manager
• Manager will complete scenarios in Jan 2023 for Q1, Q2, Q3, and Q4 day and night drills ensuring that all exits are utilized during drills for 2023.
• Staff meetings were taking place weekly after the weekly residents meetings with notes of same being kept in the managers notepad. Since the Inspection on August 11th a Notepad is now in place in each house with minutes from each meeting for all staff to read and sign.
• Communication book in place in each house for staff is now being signed by staff when</td></tr>
</table>

they have read it.
• Building upgrade and fire safety compliance remain high priorities for the BOCSI and BOCSILR. There is ongoing engagement between the BOCSI and the HSE in relation to advancing the plan for Bawnmore. This includes the following:-
o Both the Chair of the Board and CEO met with Head of Operations Disability Services (HSE) in August.
o Head of Operations Disability Services requested a revised high level plan for Bawnmore that focused more on decongregation given that this is the national policy
o This was submitted both to HSE national and local on 31st August 2022.
o A follow up meeting with Head of Operations Disability Services took place on the 1st September.
o The CEO is awaiting an update from HSE to arrange a follow up meeting in Bawnmore.
o HIQA Regional Manager updated on 15th September 2022.
o It was agreed that we would await the outcome of this engagement before resubmitting plan for Bawnmore to HIQA.
• Recruitment of staffing is ongoing and remains challenging. Every effort is made to cover residential rosters.
• As part of the IPC Checklist one of the actions will be to escalate any issues through the maintenance reporting system. Since the inspection two weekly meetings have been set up on 16/08/2022 with facilities manager where issues are escalated.
• Since inspection Risk assessment completed with advice from Facilities manager in relation to Legionella. Weekly flushing of taps and toilets and checklist in place for same.
• Meetings with staff in respect of IPC and recording of activities has taken place.
• Meeting held with ECO managing director and operations manager on the 14/09/2022 to discuss the non-compliances. Facilities manager, assistant facilities manager, Head of Integrated Services and the ADON attended this meeting. Meetings will be held quarterly going forward.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
• Ashgrove 31 and Garden View floor plans updated
• Application to Vary sent to HIQA on the 26/08/2022

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:
• Communication plan is now in the residents file.
• Going forward when a communication plan is sent for typing a copy of this plan will be kept in the residents file
• Staff meetings take place weekly with the minutes kept in the house
• All staff are now signing the communication book once read

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:
o One bedroom that is now vacant will be converted to a visitors room by 31/10/ 2022

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:
• One day service staff in place three days a week 09:30am to 16:30pm
• One CES staff in place five days a week 9am to 13:00pm
• Budget does not allow these staff to be replaced when on leave, Statement of Purpose updated on the 13/09/2022 to reflect this
• Roster Review of day service staff will take place by 31/10/2022 between all centers with a view to increasing day service support in this house to five days a week
• Activities records discussed with all staff at staff meetings held on the 13th, 14th, 20th and 21st of September. All staff minutes read and signed by all staff.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Walk around held with maintenance on 23/08/2022 to prioritize upgrade works in the designated Centre.
• Since the inspection and discussion with the Facilities manager and Head of Services the bathroom in apartment in one house has been upgraded with new shower and new tiles.
• A new oven for each house in the Designated Centre purchased .Following meeting with ECO on the 14/9/2022 a new checklist has been implemented and the cleaning of the ovens will now be on this checklist.
• Worn tablecloths replaced
• Shower head and handrail replaced.
• Wood to be replaced under the fridge in one house
• ECO cleaning manager on site met by the PIC on the 23/08/2022 to discuss the current gaps on the ECO checklist.
• Cleaning checklist updated and put in place on the 29/08/2022
• Daily spot checks taking place by ECO's manager
• Since inspection Monthly IPC Walkabout for each house completed with actions identified and discussed with the relevant staff. Actions have been escalated to Facilities manager.
Meeting held with ECO managing director and operations manager on the 14/09/2022 to discuss the non-compliances. Facilities manager, assistant facilities manager, Head of Integrated Services and the ADON attended this meeting. Meetings will be held quarterly going forward.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• Open food in a fridge discussed with all staff at staff meetings on the 13th, 14th, 20th and 21st of September.
• This will be checked by the manager during the IPC Audit each month
• All staff working in this Designated Centre have up to date food safety training completed

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Risk assessment completed in relation to Legionella
• Weekly flushing of taps and toilets and checklist in place for same .
• Fire Risk reviewed every quarter, last reviewed on the 21/09/2022
• Two weekly meetings held with Facilities Manger commenced on 16/08/2022 to support the management of the premises and identify any risks highlighted.
• Currently there are site specific risks for all the campus. A specific risk log will be put in place to reflect the designated centre by 31/10 2022

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• Visitors to the center reminded of the mandatory wearing of masks
• Maintenance team reminded of the mandatory wearing of masks
• All first Aid boxes checked and out of date items disposed and replaced
• ECO cleaning manager on site met by the PIC on the 23/08/2022 to discuss the current gaps on the ECO checklist.
• Cleaning checklist updated and put in place on the 29th August
• Daily spot checks taking place by ECO's manager
• Since inspection Monthly IPC Walkabout for each house completed with actions identified and discussed with the relevant staff. Actions have been escalated to Facilities manager.
• Walk around held with maintenance on 23rd August 2022 to prioritize minor upgrade works in the designated Centre.
• Meeting held with ECO managing director and operations manager on the 14/09/2022 to discuss the non-compliances. Facilities manager, assistant facilities manager, Head of Integrated Services and the ADON attended this meeting. Meetings will be held quarterly going forward.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Floor plans for two of the houses in the center updated with the actual layout of the house and placed in the relevant houses.
• List of fire exits in each house now in place in each fire register
• Scenarios for Fire Drills remaining by day and by night for Q3 and Q4 completed by the manager
• Manager will complete scenarios in Jan 2023 for Q1, Q2, Q3, and Q4 day and night drills ensuring that all exits are utilized during drills for 2023.
• PEEP's plan for one resident updated to reflect evacuation plan for when they are in bed.
• Fire Safety building compliance remains a high priority for the BOCSI and BOCSILR.

There is ongoing engagement between the BOCSI and the HSE in relation to advancing the plan for Bawnmore. This includes the following:-
o Both the Chair of the Board and CEO met with Head of Operations Disability Services (HSE) in August.
o Head of Operations Disability Services requested a revised high level plan for Bawnmore that focused more on decongregation given that this is the national policy
o This was submitted both to HSE national and local on 31st August 2022.
o A follow up meeting with Head of Operations Disability Services took place on the 1st September.
o The CEO is awaiting an update from HSE to arrange a follow up meeting in Bawnmore.
o HIQA Regional Manager updated on 15th September 2022.
o It was agreed that we would await the outcome of this engagement before resubmitting plan for Bawnmore to HIQA.

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:
• Manager has completed a check list to review all personal plans with keyworkers and residents.
• Goals completed will be documented clearly
• Goals requiring a review will be completed and documented clearly
• Review completed by manager on 10 out of 14 personal plans
• Remaining 4 plans will be reviewed by the manager by the 30th of September 2022.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• Resident is under the care of an eye specialist in UHL. Appointment received for resident to attend for Ophthalmologist on the 22/09/2022
• All other residents in the Designated Centre have up to date screenings on file where relevant following review of each individuals My Profile My Plan.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• 'No entry-please use other door' signage to be placed on exit door when showers are in use, portable privacy screens for use in shower/bath facilities
• One room not in use at present will be refurbished and used as a visitors room by 31/10/2022

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
Registration Regulation 8(1)	A registered provider who wishes to apply under section 52 of the Act for the variation or removal of any condition of registration attached by the chief inspector under section 50 of the Act must make an application in the form determined by the chief inspector.	Not Compliant	Orange	26/08/2022
Regulation 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	30/09/2022
Regulation 11(3)(b)	The person in charge shall ensure that having	Substantially Compliant	Yellow	31/10/2022

	regard to the number of residents and needs of each resident; a suitable private area, which is not the resident's room, is available to a resident in which to receive a visitor if required.			
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Substantially Compliant	Yellow	31/10/2022
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/10/2022
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	Not Compliant	Orange	25/05/2023

	externally and internally.			
Regulation 18(2)(a)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	30/09/2022
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.	Substantially Compliant	Yellow	31/10/2022
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	25/05/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and	Substantially Compliant	Yellow	31/10/2022

	ongoing review of risk, including a system for responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	30/09/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	25/05/2023
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	31/12/2022
Regulation 03(1)	The registered	Substantially	Yellow	26/08/2022

	provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Compliant		
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	30/09/2022
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Substantially Compliant	Yellow	30/09/2022
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal	Substantially Compliant	Yellow	31/10/2022

	communications, relationships, intimate and personal care, professional consultations and personal information.			