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:	Sonas
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Unannounced
Date of inspection:	15 November 2021
Centre ID:	OSV-0004773
Fieldwork ID:	MON-0031767

About the designated centre

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

A full-time residential service is provided for adults with an intellectual disability in this designated centre. The service supported individuals who had a range of intellectual disability, some of whom also displayed behaviours that challenge. Many of the residents in this centre have complex medical, mental health and social care needs. Many of the residents are physically dependant on staff interventions and support for all activities of daily living. Most residents did not use words to communicate and many are advancing in years. The designated centre comprises of two bungalows and a large single storey building, located on a campus in a suburb of a large city. There are four other designated centres and a day service also located on the campus. A maximum of 16 people can live in the centre. On the day of inspection there were four people living in each of the two bungalows, and six people in the larger house. The centre was staffed with two staff by day in each bungalow and four staff in the larger house. Each house had one waking staff member from 20:30 to 08:30, with assistance available from one other designated centre on site that had two night staff. The staff team was nursing lead and comprised of nursing staff and care assistants. The registered providers statement of purpose stated that the purpose of the service was to provide each resident with a safe, homely environment which promotes independence and quality care based on the individual needs and requirements of each person. The statement of purpose also describes an extensive integrated day service available to residents as well as a personal assistant programme. Both bungalows had four single bedrooms, a staff office, a kitchen, a day / dining room, two bathrooms and a utility room. Both houses had a small secure garden area to the rear. The larger house had eight single bedrooms, a kitchen, a dining room, a large open plan living room, an office, a snoezelen room, a music room, a staff room, two showers, a large bathroom area and toilets. There was a large well developed garden area to the rear.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 15 November 2021	09:00hrs to 18:30hrs	Michael O'Sullivan	Lead
Monday 15 November 2021	09:00hrs to 18:30hrs	Lucia Power	Support

What residents told us and what inspectors observed

The inspectors reviewed previously requested documentation relating to proposed building developments / plans and fire and safety proposed works within the campus. Social distancing was observed and discussion with residents and staff was limited to periods of time of less than 15 minutes in areas that were well ventilated. Hand hygiene was practiced and the inspectors and staff wore face masks. Inspectors temperatures were recorded on entry to each house.

The inspectors met with sixteen of the residents living in the designated centre. Residents had lived in the centre for many years and for some the campus and its environs was their community. Residents had complex health care needs with an increasingly high level of staff support required. Some residents ability to mobilise had greatly diminished and needed the support and assistance of staff for safe transfers as well as to meet their basic care needs in relation to eating, hygiene and general supervision. Residents appeared happy living in the centre and were very comfortable in the presence of staff. Staff engagements and interactions were observed to be respectful, gentle and unhurried.

In all houses, most residents did not use words to communicate. Staff described the work undertaken with the assistance of an additional speech and language therapist that had been employed since the previous inspection. As a consequence, residents communication resource folders had been updated and communication assessments had been completed in the previous 12 months. Supporting residents and staff in the use of LAMH and LAMH training had been impacted by the COVID-19 pandemic. There was evidence that staff had trialled pictures and photographs to both communicate with residents and offer them choice. When residents appeared disinterested in this form of communication, staff had introduced objects of reference which residents appeared to understand a little better. Some residents were using an electronic tablet to communicate with staff.

Staff were seen to be patient and respectful of residents and were observed to be working diligently to support residents. The two bungalows each had two staff employed by day. Staff were seen to facilitate a residents choice of activity to attend a swimming pool. This was something that the resident enjoyed, but its facilitation meant that three very dependant residents were in the care of the sole remaining staff member. All three residents were dependant on staff and had significant vulnerabilities and attention needs. At best the staff member ensured all three residents were supervised while attempting to clean the house, set up for meal time, attend to service contractors and assist a resident who attended the bathroom every few minutes. The facilitation of activities was limited and activities of choice based on a residents preference, were infrequent. A member of staff had been allocated to both bungalows from the day service and the intent was to provide activities and supports to each house on alternate weeks. On the day of inspection, this staff member commenced work in one of the bungalows but was reallocated to another house soon after. In the absence of day services, many residents activities were

limited to the confines of the campus and activity records reflected that residents had gone for a walk or listened to music. The greater proportion of activities related to walks or listening to music. Social work notes reflected that the residents world had become very small. Residents no longer availed of access to personal assistants as the contractor was no longer in a position to supply assistants. The registered provider did not ensure that residents had been supported to seek an alternative service.

The two bungalows had been identified by the registered provider for major refurbishment. While a refurbishment project had been commenced in other parts of the campus, progress was slow and the project was behind previously set time lines. Despite this, the registered provider had successfully transitioned 11 residents to community based houses off campus in the previous 12 months.

The living conditions for residents in both houses were poor. The internal building fabric was in poor repair and the buildings were small and uninviting. Residents had no private or personal space of note. Communal areas were drab and dirty. Designated clean areas for the donning and doffing of personal protective equipment (PPE) were not clean. Each house was decoratively aged and surfaces were in poor condition. The houses did not meet the assessed needs of the residents that lived in them. Fire doors and fire safety works were required. Cleaning contractors were engaged for 30 minutes for 3 days a week to clean floors and surfaces. The burden of basic cleaning and additional cleaning routines to prevent the spread of infection was allocated to the staff on duty. This further eroded the amount of time that staff could engage individually with each resident. The delivery of care was driven by the work and tasks that had to be done rather than afford residents a person centred or individual service.

The third house was larger and in good decorative order. Bedrooms were small but each one was personalised and homely. There was significant space to afford residents privacy and communal spaces were well maintained and furnished. This house was also awaiting the progression of a major refurbishment and the installation of fire doors. This house had no glazing in the windows with the exception of the staff toilet. Perspex sheets had been installed at the time of original construction. The Health Services Executive had noted this on previous fire and safety assessments and a determination in relation to the materials suitability remained outstanding.

In summary, the inspectors found that each resident's general care was maintained by staff who were working hard. There was not a strong and visible social model of services within the designated centre. Residents rights and general welfare were impeded by limited staff allocations that were not consistent with the current assessed needs of residents with multiple and complex needs. The designated centre, overall, was not sufficiently resourced to meet the assessed needs of residents.

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

delivered to each resident living in the centre.

Capacity and capability

The inspectors found that the designated centre overall, was not well managed to meet the assessed needs of residents. There had been improvement with the relocation of residents to community based accommodation, however, regulatory non compliance since the previous inspection had significantly increased. Staff had a good understanding of residents needs and residents appeared happy and well cared for. The focus of support was not person centred and some physical environments remained poor while the registered provider awaited the delivery of a major refurbishment project.

The registered provider had in place a team of staff that were trained to meet the assessed needs of residents. The person in charge was employed in a full-time capacity and had commenced in the service in February 2020. The person in charge was an experienced and suitably qualified person. Staff communication with the person in charge was either face to face or by mobile phone. The person in charge conducted staff performance reviews for all staff. Staff stated that they were well supported by the person in charge. The person in charge received supervision and direct support from the person participating in management. Staff numbers allocated to the designated centre afforded limited person centred care while there was evidence that some activities were facilitated in residents homes in the absence of structured day services. The allocation of staff was consistent with the safeguarding and protection needs of residents, however, the allocation of staff in two of the houses was consistently only two staff members. This provided less opportunity for these residents to engage in external activities either on or off the campus and ones of individual choice. The physical needs of some residents required the attention of two staff at times.

The provider had in place a training schedule for all staff. Mandatory training provided by the registered provider had not been effected by the COVID-19 restrictions. The training matrix records of 50 staff were reviewed. These records were for staff who worked in the designated centre across day and night duty. All staff had current training in fire and safety, the management and prevention of aggression and safeguarding vulnerable adults. Staff training records demonstrated recent training in infection control as well as the proper use of personal protective equipment (PPE). All staff had undertaken food hygiene training and manual handling.

All notifications had been made to the Chief Inspector, within the required three day period. All reported incidents to the Health Information and Quality Authority (HIQA) were consistent with the registered provider's records. The registered provider had in place a directory of residents that contained all the requirements as specified by Schedule 3 for all 16 residents. The inspectors reviewed a complaints log which

included a complaint that the registered provider had addressed since the previous inspection. In all, there was only one registered complaint since 2020.

The registered provider had arranged for six monthly reviews of the designated centre. Residents and their families were involved in this process and their views recorded in the document. Records were available that demonstrated that team meetings, management meetings and multidisciplinary meetings were taking place and properly recorded. An annual review of service had also taken place. Improvements that were required were highlighted, particularly in the areas of resources and staff issues. The registered provider had in place a time-bound plan for the purposes of bringing the designated centre into compliance regarding regulations pertaining to premises and fire safety. The delivery of this plan had been delayed due to funding issues as well as the pandemic. In the interim, there were no plans or improvement measures in place for the residents who continued to live in substandard living accommodation while the overall project awaited delivery. Resident meetings were facilitated and recorded. Records reflected that activities and events, menu planning, self care and the COVID-19 pandemic were discussed with residents.

The registered provider had in place a statement of purpose that was an accurate description of the service provided on the day of inspection. The conditions of registration were clearly outlined and a copy of the registration certificate was on display in the designated centre.

Regulation 14: Persons in charge

The registered provider had employed a person in charge in a full-time capacity who was suitably qualified and experienced for the role.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had not ensured that the qualifications, skill mix and experience of staff was appropriate to the assessed needs of the residents. Residents had complex health care needs with an increasingly high level of staff support required. Some residents ability to mobilise had greatly diminished and needed the support and assistance of staff.

Judgment: Not compliant

Regulation 16: Training and staff development

The person in charge ensured that all staff had access to mandatory training.

Judgment: Compliant

Regulation 19: Directory of residents

The person in charge maintained an accurate and up-to-date directory of residents.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had not ensured that the designated centre was properly resourced to provide effective and safe care to residents. Staffing allocations did not reflect the degree and complexity of residents assessed needs. Living accommodation was in poor repair and physical fire and safety measures had not been installed.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The registered provider ensured that each resident had a contract of admission in place that clearly outlined terms and conditions of residency.

Judgment: Compliant

Regulation 3: Statement of purpose

The registered provider had a statement of purpose in place that was subject to annual review and accurately reflected the current provision of services due to the pandemic.

Judgment: Compliant

Regulation 31: Notification of incidents

The registered provider had ensured that all notifiable incidents had been made to the office of the Chief Inspector within three working days of occurrence.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had a current complaints log that was maintained by the person in charge.

Judgment: Compliant

Quality and safety

The inspectors noted that there had been no overall improvement in the quality and safety of services since the previous inspection with a marked deterioration in regulatory compliance. The focus of service delivery was mainly task oriented with little attention to the significant assessed needs and required support of residents. Residents had little access to day services on the campus and limited opportunities to take part in activities off campus. Personal assistants were no longer available to residents. Individual activities and choice to residents in two houses were less likely to occur due to the low levels of staff compared to the residents assessed needs and complex needs for support. Staff were observed to be kind, gentle and respectful of residents, however the poor design, layout and condition of premises prevented personal and meaningful engagement. All houses awaited the delivery of refurbishment and renovation works as well as the installation of fire safety measures. Some residents had been successfully transitioned to community based houses.

The two bungalows provided little additional space to residents as a result of reduced resident numbers. All residents had a single occupancy bedroom, however these rooms were small, sparse and poorly decorated. The fabric and decor of these houses had further deteriorated since the previous inspection. There was little room for the storage of possessions. There were no private spaces and the communal areas were also functional room used for dining and watching television. In the larger house, bedroom spaces had been enhanced and these were homely and

personalised. This house was maintained to a good standard but windows had no glazing. Perspex sheets had been installed at the time of construction and had remained in place. This premises was notably cooler than other houses.

The inspectors reviewed the individual care plans and notes relating to residents. Care plans had been updated but did not reflect the degree and complexity of residents current assessed needs. It was clear that all residents had been in receipt of regular health assessments and their health needs were reviewed by staff working within their homes as well as allied health professionals. These professional inputs were specific to the assessed physical and medical needs of the residents in question. Clear preventative measures and treatment procedures and strategies were well documented. Residents with identified conditions had clear instructions from their attending consultant on record, including clear medicine and emergency intervention protocols. Sensory input was directed by assessment and occupational therapy interventions. Records demonstrated staff trialling suggested interventions and modifying care plans based on the results. Some residents communication passports had been updated after speech and language assessment. Additional interventions were subject to further staff training that had yet to happen. The hospital passports of residents were well maintained.

Staff in conjunction with the multidisciplinary team were working hard to assess and support residents with communication deficits. A large number of residents communication needs had been reassessed and the employment of an additional speech and language therapist since the previous inspection was driving this process. Some staff training had occurred but more was awaited to enable staff to offer alternative means of communication to residents. Some residents were using assistive technology to communicate. The guide available to residents was current and in an easy-to-read format.

Residents rights and general welfare were impacted primarily by low staffing levels in two bungalows which did not assure that residents with complex assessed needs and conditions had the freedom to exercise choice and control of their daily lives. External activities off campus were limited and the greater proportion of on campus activities related to walks and listening to music. Residents who previously had access to personal assistants, no longer had access to such a service. The contractor who had previously supplied personal assistants was no longer able to. The registered provider had not sought or supported residents to access an alternative service. General activation staff were allocated to residents from day services, however, the frequency and commitment of this resource was sporadic. Some residents were in receipt of reflexology and records reflected that residents very much enjoyed this as an activity. Records did not reflect whether residents were supported to consent to taking part in an activity or to consenting to paying for the activity. The registered provider was requested on the day of inspection to conduct an audit in relation to the number of residents and the amounts of residents funds committed to provision of such activities. It was noted that staff maintained an accurate record of all residents monies spent with receipts and double signatories.

All main meals were delivered to the designated centre from an outside contractor. The food on the day of inspection was observed to be wholesome and nutritious,

however, residents choices had to be made two weeks in advance of food delivery. The individual residents actual choice for a given day was known to staff who were familiar with the resident but there was no record retained to support the choice made. Residents spoken with were not aware of the food choices available to them on the day of inspection. Some kitchenette facilities did not allow for residents to be supported in the preparation or cooking of food.

There were a number of restrictive practices in place in all houses. Each resident had a risk assessment in place that assessed the impact of the restriction on them. Positive behaviour support plans had been subject to review and had been updated.

Residents had current safeguarding plans in place that were subject to ongoing review. Safeguarding notifications had been appropriately closed off on the instruction of the Health Services Executive Safeguarding team.

On the day of inspection, it was evident that staff had undertaken training in relation to the proper use of PPE. Staff had also undertaken educational modules in relation to infection prevention control. Stocks of PPE were held centrally on the campus and it was observed that sufficient stocks were in place in each house. Hand sanitizer stations were located throughout all houses with staff observed to use these effectively. Clinical waste bins were at each exit for the safe disposal of used PPE. All visitors to a house were required to sign in and have their temperature recorded by a member of staff. Staff allocations were monitored to ensure that there was limited crossover and contact between the staff in each house. Current public health guidelines were seen to be adhered to. External contract cleaning was limited to 30 minutes in each bungalow, three days a week. Staff were undertaking all of the cleaning duties, including the cleaning of frequently touched areas. The person in charge has also completed a self assessment to determine the registered providers readiness to address a COVID-19 outbreak. This was an amalgam of both the registered providers assessment of preparedness and that which HIQA had issued to services. This was a checklist type audit that indicated the registered providers satisfaction with the cleanliness of houses. On the day of inspection floors, skirting, walls, showers, furniture and designated clean rooms were noted to be dirty in two bungalows.

On the previous inspection, fire and safety issues had been highlighted to the registered provider. Principal matters to be addressed included the installation of fire doors, door closures and assurances regarding the safe evacuation of residents in the event of a fire. Each resident had a clear and current personal emergency evacuation plan. Each house had a weekly fire checklist that staff adhered to. Staff practices were observed to be of a good standard - fire exits were clear and fire evacuation drills were taking place. Simulated fire drills were occurring at times of minimum staffing levels. The fire alarm system, the emergency lighting system and all fire extinguishers had been serviced in the current year. All staff had undertaken mandatory fire and safety training. The installation of fire doors and door closures were awaited as part of the registered providers action plan.

Since the previous inspection the registered provider had undertaken a review of its risk register and risk assessment process. The risk register for the designated centre

was comprehensive and was in the process of been updated. The risk register also reflected the COVID-19 pandemic and the risks associated with infection.

Regulation 10: Communication

The registered provider was working to ensure that each resident was assisted and supported to communicate in accordance with residents needs and wishes. Some staff training had occurred but more was awaited to enable staff to offer alternative means of communication to residents.

Judgment: Substantially compliant

Regulation 12: Personal possessions

The registered provider did not provide evidence that ensured that all residents were supported to make decisions in regard to how personal funds were spent on therapies. Some residents also had limited space to store personal items and possessions.

Judgment: Substantially compliant

Regulation 13: General welfare and development

The registered provider had not ensured that the residents had both the opportunity and facilities to take part in recreation activities of their choosing. Residents had limited access to meaningful activities and residents no longer had access to a personal assistant. Many activities were confined to the general campus.

Judgment: Not compliant

Regulation 17: Premises

The registered provider had not ensured that premises were designed and laid out to meet the assessed needs of residents. Two bungalows were small and poorly decorated while awaiting a complete refurbishment. A larger house had perspex instead of glazing in windows.

Judgment: Not compliant

Regulation 18: Food and nutrition

The person in charge ensured that residents had a diet that afforded variety and choice, however there were no facilities to allow residents cook food. Food choices offered to residents were two weeks in advance and no record was maintained of the choice residents made.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider had a residents guide that was up to date.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had in place a risk management policy and a current risk register that included COVID-19 risks.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider ensured that all residents were protected from the risk of healthcare and COVID-19 infection, however, the standard of cleanliness and the limited resources allocated to the general cleaning and upkeep of two bungalows fell short of the requirements to comply with regulatory and national infection control standards.

Judgment: Not compliant

Regulation 28: Fire precautions

The registered provider had in place an effective fire and safety management system in place, however the installation of fire doors and fire door closures were still awaited as part of a larger refurbishment project.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The person in charge ensured that residents personal plans were relevant and subject to annual review, however these plans did not reflect the degree and complexity of residents current assessed needs.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider ensured that each resident had a healthcare plan that was based on the residents personal plan.

Judgment: Compliant

Regulation 7: Positive behavioural support

The registered provider had a restrictive practices log in place in each house and these were subject to regular multidisciplinary review.

Judgment: Compliant

Regulation 8: Protection

The registered provider ensured that each resident was assisted and supported to protect them from abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider had not ensured that the designated centre was operated in a manner to respect each resident. Residents rights and general welfare were impacted primarily by low staffing levels in two bungalows which did not assure that residents with complex assessed needs and conditions had the freedom to exercise choice and control of their daily lives. External activities off campus were limited and the greater proportion of on campus activities related to walks and listening to music.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Not compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Sonas OSV-0004773

Inspection ID: MON-0031767

Date of inspection: 15/11/2021

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

- Staffing levels are reviewed on continuous basis and we continue to endeavor to provide consistent staffing day and night whilst also complying with public health requirements relating to Covid.
- Risk Assessment to be completed to determine required staffing levels in Cedar 4 and Cedar 5 to support Quality and Care of residents. If indicated a business case for additional staff will be submitted to the Funder.
- In the normal course of events a day service staff (9am – 5pm) is allocated between two of houses in the designated centre. On the day of inspection this staff was redeployed to another house in response to covid risk.
- The PIC endeavors to fill the full roster daily but at times, in the current pandemic, this is not always possible.
- HR are actively recruiting staff but there are challenges in recruitment at present.
- The risk assessment has been completed by the PIC and PPIM and does indicate the requirement for additional staffing by day to support the residents.
- This will be discussed with the MDT supporting the residents at a meeting to be scheduled and a business case will be submitted to the HSE for funding. This work will be completed by 31st January
- This business case will be placed on the agenda for the business case meeting for February 2022.
- Currently there is a day service staff assigned to each bungalow (Cedar 4 and Cedar 5) every second week. It is noted that there are, at times, challenges with filling this roster given the pressures on staffing in the context of the pandemic.
- The business case will look to include a relief component for the additional staff as currently the BOCSILR is not funded for the replacement of day service staff.
- Currently the company that was tendered to provide a PA service does not have staffing available to provide this service.
- The BOCSILR will look to retender for this PA service in Q1 2022.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• Staffing levels are reviewed on continuous basis and we continue to endeavor to provide consistent staffing whilst also complying with public health requirements relating to Covid.

• Risk Assessment to be completed to determine required staffing levels in Cedar 4 and Cedar 5to support Quality and Care of residents. If indicated a business case for additional staff will be submitted to the Funder

• A revised capital upgrade plan was presented to HIQA on 19th November and a detailed report, in line with this presentation, will be submitted to HIQA by 21st December 2021.

• Ashgrove 34 fire safety and heating upgrade works commenced during 2021 It is anticipated this work will be completed by the end of Q1 2022.

• Cedar Drive 1 fire safety and heating upgrade works commenced on 02/11/2021. It is anticipated this work will be completed by 30th June 2022.

• There is a system in place for addressing maintenance issues as they arise. These are prioritized by the person in charge and are scheduled in consultation with facilities management.

Regulation 10: Communication	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication:

• All residents in the centre have been referred for communication assessments. Individuals are prioritized within integrated services based on impact & risk.

• Since the opening of Sonas designated centre 10 residents have had communication assessments completed and implemented.

• 2 residents have had an external sensory OT input, and another 2 residents to be included on the waiting list for 2022 based on current review of priorities within the wider service.

• Risk assessments in place due to access to speech and language communication assessments and occupational therapy sensory assessment continued to be monitored quarterly by PICs and ADON.

• A review of the rollout of LAMH training will take place with the Senior SLT in Q1 2022 to determine when training be scheduled.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

· All residents have a Person centred plan.
· Residents are supported by their keyworker and members of the Multidisciplinary team in decisions about their life.
· Decisions are made based in the best interest of the resident bearing in mind the Assisted Decision making Act currently under review.
· Where will and preference can be established for an individual this will inform the decision.

• This can often be highlighted through the Person centred plan or through the MDT process or through the weekly house meeting.
• Reflexology is a therapy that is enjoyed by many residents, over many years. It's a valuable therapy which residents appear to enjoy with the added therapeutic benefits.
• The reflexologist will always engage with the resident and feedback to staff following each session.

• All residents have access to therapies they may enjoy. These therapies are not provided as part of the services provided directly by the BOCSILR. They are sourced externally by the BOCSILR.
• The BOCSILR has a policy to oversee how residents money is spent.
• A review of a second of this policy (Appendix 10) is currently in process that will further support this important oversight.

Regulation 13: General welfare and development	Not Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development:

• Resident's activities discussed with all staff members during support and supervision.
• New Activity template to be devised in January 2022 for the centre to include additional information on chosen activity, detailed description, engagement and response from resident to reflect accurately the level of activities that are taking place.
• Activity records for the centre will then be reviewed monthly by the PIC, any actions to improve activities and documentation will be addressed with staff following each review.
• PCP reviews discussed with all keyworkers in supervisions - where priorities are delayed due to Covid 19 alternative actions are identified.
• Where delay is substantial additional priorities will be added which can be progressed during the current pandemic.
• If indicated from risk assessment, a business case for additional staffing will be

submitted to the funder in 2022.

Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • A revised capital upgrade plan was presented to HIQA on 19th November and a detailed report, in line with this presentation, will be submitted to HIQA by 21st December 2021. • Ashgrove 34 fire safety and heating upgrade works commenced during 2021. It is anticipated this work will be completed by Q1 2022. • Cedar Drive 1 fire safety and heating upgrade works commenced on 02/11/2021. It is anticipated this work will be completed by 30th June 2022. • There is a system in place for addressing maintenance issues as they arise. These are prioritized by the person in charge and are scheduled in consultation with facilities management. • A deep clean occurred of Cedar Drive 4 & 5 on 16/11/2021.	
Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: • Residents in the designated centre are supported to have choice in respect of their meals. • On the day of inspection the individual recording sheets for residents, to evidence this, could not be located. These forms are completed every 2 weeks alongside the main order and kept for reference by all staff. Staff have been reminded of the importance of having these completed and filed and at hand. • Where a resident looks for specific food this can facilitated outside of the 2 week ordering process.	
Regulation 27: Protection against infection	Not Compliant
Outline how you are going to come into compliance with Regulation 27: Protection	

against infection:
• There is regular cleaning provide by outside contractors for each bungalow in the designated centre.
• The top of the bin in the clean room had not been wiped down and this was visible and cleaned following inspection.
• There was dust observed behind the couch and padding in one area, was cleaned following the inspection.
• Meeting with cleaning company to review their schedule of cleaning to ensure the bungalows are clean.
• The PIC will continue to complete the monthly Infection Prevention and control walkabout and address any arising issues immediately.
• Staff reminded the importance of infection control, and completing of documentation.
• Deep Clean was completed in Cedar 4 and 5 16/11/2021.
• The current cleaning roster is 45 minutes 3 days per week.
• The PIC met with the Cleaning Supervisor the day after the inspection to provide feedback.
• Following this meeting the Cleaning supervision circulated the name of each cleaner assigned to each bungalow so that the PIC has clarity as to who provides this cleaning service.
• The PIC has spoken to staff and requested that if there was any issue with the cleaning service on the day that the PIC or the CNM2 on duty will be advised so that immediate follow up can take place.
• It is noted that both Cedar 4 and Cedar 5 require upgrading and this will be prioritized with the Facilities Manager and completed by Q2 2022. The medium term plan is for these bungalows to close and for residents to relocate to new purpose built homes in Pallasgreen.
• As part of the monthly "walk around" checks the PIC will monitor the cleaning of both houses and will link with the Cleaning Supervisor if there are any concerns with the standard of cleaning.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A revised capital upgrade plan was presented to HIQA on 19th November and a detailed report, in line with this presentation, will be submitted to HIQA by 21st December 2021.
• Ashgrove 34 safety and heating upgrade works commenced during 2021. It is anticipated this work will be completed by Q2 2022.
• Cedar Drive 1 fire safety and heating upgrade works commenced on 02/11/2021. It is anticipated this work will be completed by 30th June 2022.
• There is a system in place for addressing maintenance issues as they arise. These are prioritized by the person in charge and are scheduled in consultation with facilities management.
• First Responders training has been completed with relevant staff.

• All fire evacuations are now completed in full.

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:
• Risk Assessment to be completed to determine required staffing levels in Cedar 4 and Cedar 5 to support Quality and Care of residents. If indicated a business case for additional staff will be submitted to the Funder.
• Communicatin assessments will continue to be rolled out in 2022. 10 have been completed in 2021.
• Prioritization for OT Sensory assessmentgs will take place in Q1 2022.
• Engagement with Senior SLT will take place in Q1 2022 re the rollout of LAMH in 2022.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Risk Assessment to be completed to determine required staffing levels in Cedar 4 and Cedar 5 to support Quality and Care of residents.
• A business case will be submitted if indicated requesting funding for additional staff.

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 10(1)	The registered provider shall ensure that each resident is assisted and supported at all times to communicate in accordance with the residents' needs and wishes.	Substantially Compliant	Yellow	31/12/2022
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Substantially Compliant	Yellow	31/12/2022
Regulation 12(3)(d)	The person in charge shall ensure that each resident has adequate space to store and maintain his or her clothes	Substantially Compliant	Yellow	31/05/2023

	and personal property and possessions.			
Regulation 13(1)	The registered provider shall provide each resident with appropriate care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.	Not Compliant	Orange	31/12/2022
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Not Compliant	Orange	31/01/2022
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with their interests, capacities and developmental needs.	Not Compliant	Orange	31/12/2022
Regulation 13(2)(c)	The registered provider shall provide the following for residents; supports to develop and maintain personal relationships and links with the	Not Compliant	Orange	31/12/2022

	wider community in accordance with their wishes.			
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	31/12/2022
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	31/05/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	31/05/2023
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	16/11/2021
Regulation 17(7)	The registered	Not Compliant	Orange	31/05/2023

	provider shall make provision for the matters set out in Schedule 6.			
Regulation 18(1)(a)	The person in charge shall, so far as reasonable and practicable, ensure that residents are supported to buy, prepare and cook their own meals if they so wish.	Substantially Compliant	Yellow	20/12/2021
Regulation 18(2)(c)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which offers choice at mealtimes.	Substantially Compliant	Yellow	20/12/2021
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/05/2023
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	31/05/2023

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	30/06/2022
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	31/05/2023
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.	Not Compliant	Orange	31/05/2023
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/05/2023

Regulation 05(1)(a)	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 prior to admission to the designated centre.	Substantially Compliant	Yellow	31/12/2022
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).	Substantially Compliant	Yellow	31/12/2022
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/12/2022
Regulation 09(2)(a)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability participates in and consents, with supports where	Not Compliant	Orange	31/12/2022

	necessary, to decisions about his or her care and support.			
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 freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	31/12/2022
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 communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	31/05/2023