



Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Corrib Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Galway
Type of inspection:	Short Notice Announced
Date of inspection:	24 August 2021
Centre ID:	OSV-0004858
Fieldwork ID:	MON-0033789

About the designated centre

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

Corrib Services is a designated centre, which supports residents with a low to moderate intellectual disability. The centre can also support the broader needs of residents including their overall health needs. The centre is comprised of two houses located in residential areas on the outskirts of the city. The houses are in close proximity to each other and, each house is registered to provide accommodation for six residents. Each resident has their own bedroom and a large number of these bedrooms have en-suite facilities. Residents share kitchen, dining and living areas and, the gardens. A social model of care is provided in the centre and, residents are supported by both social care and support workers. The staff and management skill-mix does provide for nursing input and, oversight. A staffing presence is maintained at all times when residents are present and, a sleepover arrangement of one staff member is used to support residents during night time hours in each house. Transport is available for residents to access the community, and public transport services are located within walking distance of the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11
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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
Tuesday 24 August 2021	10:30hrs to 17:00hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection focused on one of the two houses that comprise this designated centre. There was much evidence to support that this was a good service and, overall a high level of compliance with the regulations was evidenced. However, a sequence of events, some of which were outside of the control of the provider, had combined to exacerbate the differing and, at times incompatible needs of the residents who lived in this house. This impacted on the safety and quality of the service experienced by residents. There was evidence of measures taken by the provider to reduce the risk that presented. However, the provider itself had identified that to improve the quality and safety of residents lives, the provider needed to reduce the occupancy of this house based on an assessment of needs, compatibility and risks. While the provider was optimistic that this would be achieved and there was discussion of preliminary plans, this safeguarding risk was not resolved at the time of this inspection.

This inspection was undertaken with due regard for the ongoing requirement for measures to reduce the risk of the accidental introduction and, onward transmission of COVID-19. Given the number, the needs and, the limitations on space in the house itself, the inspector reviewed records, met and spoke with the person in charge and, the service co-ordinator in the provider's administration offices. The inspector then went to visit the house to meet with the residents and, the staff on duty. Infection prevention and control measures and, ongoing vigilance were evident throughout the day. To date, this vigilance has effectively protected both staff and residents from the risk of COVID-19.

The inspector noted that the house was located in a mature, pleasant estate and, the house presented well. Staff told the inspector that the neighbourhood was inclusive and, residents had a good relationship with their neighbours. Three residents were waiting to greet the inspector. Residents were warm, gracious and, engaged as they welcomed the inspector to their home. Staff and residents had been advised to continue with their planned routines for the today and, the remaining three residents were out and about in the community with a staff member. Even with these three residents and a staff member absent from the house, the inspector could see this was a busy and active house and, while a large house, some areas such as the kitchen were compact. Every available space was used with the exception of the attic space. Staff were in the process of converting this space to an office as currently they did not have a dedicated office space in the house. The inspector could see why the provider had identified the need to reduce the occupancy of this house. The inspector also recognised the diversity of the personalities of the residents present.

The inspector saw that the house was fitted with emergency lighting, a fire detection and alarm system, fire-fighting equipment and, doors with self-closing devices designed to contain fire and its products. However, the space beneath the

stairs was used as a storage space and contained flammable items.

All three residents presented as in good form, were relaxed with the presence of the inspector and, evidently quite comfortable with the person in charge and, the staff on duty. There was an air of homeliness with the evening meal cooking and, laundered clothes drying on the line. One resident told the inspector that he had prepared the evening meal with staff and, had also baked some banana bread. The resident was very aware of his personal plan and discussed his planned personal objectives for 2021. The resident was hoping and planning to have a short break away in a hotel. The resident offered to show the inspector around the house but the remaining two residents also came and observed with interest. Staff respected resident right to privacy and, asked residents if they would like to show the inspector their bedrooms which they did. It was obvious to the inspector that residents had a sense of ownership and pride in their home and, their own personal space within it. Another resident told the inspector about his part-time work and, how happy he was to have returned to it. There was a pleasant paved area to the rear of the house that was evidently used on a daily basis. One resident had a swing garden chair and, there was adequate outdoor seating for all six residents. Residents were hoping that the inspector would meet the cat who was obviously a welcome visitor on a daily basis from a neighbouring garden.

The time spent in the house with residents was a very pleasant experience with refreshments offered and, residents anxious to know if the inspector was going to be back the following day. The inspector did not ask any leading questions and, these three residents did not raise any particular concerns. Staff said that this was not unusual as the dynamic within the house fluctuated and, was managed in so far as was possible by the routine of the house, for example the community outing for three residents on the afternoon of the inspection. However, the inspector did see from records reviewed that residents had raised concerns about life in the house. For example, a resident had reported feeling afraid of a peer, a resident choose to eat their meals on their own and, a resident went to their bed room during periods of disturbance in the house. Residents were listened to and, the impact on them was recognised and accepted by the provider.

However, the provider did need to review and improve its systems for evaluating the quality and safety of the service and, for seeking and using feedback from residents and, their representatives so as to inform that evaluation. The inspector saw that the six-monthly internal quality and safety reviews were on schedule but based on records seen the annual reviews were not. While the outstanding annual review for 2020 had now been completed, it referenced outdated feedback received from representatives in 2019. This feedback was positive but there had been considerable change and, impact from that change in the interim that would not have been captured in that feedback.

In addition, the provider needed to ensure that when it did identify matters that were impacting on the quality and safety of the service and residents lives, these matters were resolved in a timely manner. The findings of the internal reviews referred to above and other records seen by the inspector indicated that the impact

of needs that were not compatible was an issue in this house for some time.

As stated in the opening section of this report a sequence of events had exacerbated the known incompatibility. COVID 19 restrictions had brought significant change to the daily routine of residents who had enjoyed active, full lives with access to work, to volunteering and, to external day services. All of this stopped and, residents spent much more time together in the house. Residents had at times depending on restrictions, less access to home and family. In addition, the management structure of the service had been reconfigured by the provider in early 2021 and, this reconfiguration resulted in a new management team and structure. This reconfiguration brought further change for residents in terms of the day services they could access. The established team leaders in each house had retired. The cumulative impact of all of this change on residents was evident in the pattern of negative peer to peer interactions submitted to HIQA (Health Information and Quality Authority).

Having reviewed records and having spoken with the local management team, the inspector was assured that the need to address the risk arising in this house was being actively managed by the new management team supported by the wider multi-disciplinary team (MDT), including safeguarding personnel. The risk arising and, the requirement for a speedy resolution was escalated to senior management and, was consistently monitored by the person in charge. However, despite the escalated concerns for resident safety and well-being and, and possible solutions, the matter was not yet resolved.

While the opportunity to observe practice was limited, the inspector was assured from records seen and the time spent in the house that on a day to day basis the management and staff teams worked to address the impact of the many changes and, to minimise the risk of negative peer to peer interactions between residents. For example, while not full-time, a range of opportunities for off-site day activities had been put in place. The staff rota had been revised so as to maximise consistency and, family visits and visits to home had recommenced. The inspector saw that there was good input and support for residents and staff from the wider clinical team. Recommended interventions were observed to be in use such as a daily visual schedule and, programmes design to promote more positive responses and behaviours.

In addition, the inspector was assured that there was good oversight of each resident's overall health and well-being and, residents had good access to the range of clinicians and services that they needed. However, all records seen by the inspector and, all persons spoken with agreed, that while there would always be a need for supportive interventions in response to assessed needs, a purposeful reduction in the overall occupancy levels of the house was needed.

The next two sections of this report will present the findings of this inspection in more detail 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.

Capacity and capability

As stated in the opening section of this report a reconfiguration of the services in early 2021 had resulted in a complete restructuring of the management team of this service. This had resulted in further change for residents and, possibly some inconsistency. However, the inspector was assured that the current management structure was effectively managing and overseeing the service and, was actively seeking to ensure that residents were provided with a safe, quality service. The centre presented as adequately resourced. There were evident functioning systems of oversight but the provider was not effectively completing the annual review of the quality and safety of the service as required by the regulations. While there was evidence of actions taken to mitigate the risk posed by the differing and at times incompatible needs of the residents, this matter had not been resolved in a timely manner by the provider.

The management structure was clearly defined and, individual roles, responsibilities and reporting relationships were understood. The management team comprised of a team leader in each house, supported by the service co-ordinator who reported to the person in charge who was the area manager. The person in charge had other areas of responsibility including two other designated centres but was clearly well informed of the matters arising in this centre and, was actively engaged in the management and oversight of the centre. For example, there was evidence of consistent and ongoing collaborative working between the team leaders, the person in charge, the service co-ordinator and, the wider MDT. There was an evident understanding of the matters that were limiting the quality and safety of the service and, a shared commitment to resolve this so as to make life better for residents and for staff. The person in charge escalated to senior management the matters that were beyond their scope of responsibility to address. This oversight and escalation was clearly documented.

However, notwithstanding this robust evidence of active management, the inspector was not assured that the provider was effectively collecting data and using it in a timely manner to assure and improve the quality and safety of the service provided to residents. For example, six-monthly internal reviews completed in November 2020 and in May 2021 both highlighted the failure to complete for the previous year, the annual review of the quality and safety of the service required by the regulations. The annual review for 2020 had now been completed and it captured the many challenges and changes encountered by residents in 2020 and, reported a significant increase in incidents when compared with the previous twelve months. However, this information should have been collated in a more timely manner so as to highlight the deterioration in both quality and safety. In addition, the annual review did not provide for updated consultation with representatives and cited feedback that had been provided in 2019.

The six-monthly reviews, based on the records seen by the inspector, were completed on schedule and did provide for consultation with residents and staff.

These reviews however relied on the annual review to elicit feedback from representatives. The reviews did focus on residents and, the quality and safety of their service. The findings of these internal reviews captured the matters arising in this house and the requirement for a resolution. The findings also however, demonstrated the failure to resolve the matter in a timely manner. For example, it was reported that a resident had in May 2019, raised misgivings about living with a peer and, this had escalated to the resident reporting feeling afraid, by the time of the review completed in May 2021. The need to reduce the occupancy of the house had been cited in the internal review completed in November 2020 and, at a staff meeting held in September 2020. Staff raised their concerns again during the May 2021 internal audit and, at a staff meeting in August 2021.

The provider did monitor the adequacy of it's staffing levels and, recognised the important role of staffing and skill mix as a measure to reduce the risk arising in this house. Prior to COVID-19 when residents were out and about, the house may not have been staffed by day. Staff were now present in the house all day. Based on the sample of rotas reviewed by the inspector consistency of staffing was considered and, two staff were on duty generally from mid morning up to 19:00 or 20:00hrs. The inspector saw a recent request from the person in charge for additional staff support at the weekends. The team leader who prepared the staff rota confirmed that this was sanctioned as needed, for example if the house was at full occupancy.

Notwithstanding the general challenges that have arisen to providing staff with baseline and refresher training, based on the sample of records seen, no gaps were identified in staff attendance at training. Mandatory, required and desired training attendance was in date and, this included a suite of infection prevention and control training. In general, while staff training needs did issue as an action from internal reviews, the inspector noted that staff completed a broad range of training including programmes facilitated by HIQA and, training that reflected the assessed needs of the residents. This training including training on dementia, diabetes and, working with residents to pursue their personal objectives. Staff had input from the MDT to support them in their work. The person in charge confirmed that staff supervisions were completed and, the recently recruited team leaders were in receipt of supervision and training to support them their role.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted a complete and valid application seeking renewal of the registration of this centre.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was an experienced manager with the skills and qualifications needed for the role. The person in charge took accountability for the service given their role and responsibilities in the overall governance structure. It was evident to the inspector that the person in charge was actively involved in the management and oversight of the service and, advocated for a safe, quality service for residents.

Judgment: Compliant

Regulation 15: Staffing

The provider monitored the adequacy of its staffing levels and arrangements and, made adjustments in response to changes such as the absence of day services. The planning of the staff rota sought to ensure consistency of staffing so that staff were familiar with the needs of the residents and how to support them. The staff skill-mix and, the management structure provided for nursing input and oversight.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to and, had completed a broad range of training that reflected mandatory requirements and, the assessed needs of the residents.

Judgment: Compliant

Regulation 21: Records

The records in the centre were well-maintained and, were readily available as needed by the inspector. The records were of a standard that readily informed and validated the inspection findings such as the oversight and monitoring of resident-well being and, the pathway of escalation as referred to in the body of this report.

Judgment: Compliant

Regulation 22: Insurance

With it's application seeking renewal of registration, the provider submitted evidence

of having contacts of insurance.

Judgment: Compliant

Regulation 23: Governance and management

The inspector was not assured that the provider was effectively collecting data and using it in a timely manner to assure and improve the quality and safety of the service provided to residents. The findings of internal reviews captured the safeguarding matters arising in this house and the requirement for a resolution. The findings also however, demonstrated the failure to resolve the matter in a timely manner.

Internal reviews completed in November 2020 and in May 2021 both highlighted the failure to complete for the previous year, the annual review of the quality and safety of the service required by the regulations. The annual review for 2020 had now been completed and it captured the many challenges and changes encountered by residents in 2020 and, reported a significant increase in incidents when compared with the previous twelve months. However, this information should have been collated in a more timely manner so as to highlight the deterioration in both quality and safety. In addition, the annual review did not provide for updated consultation with representatives and cited feedback that had been provided in 2019.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose contained all of the required information such as details of the management structure and staffing levels and, how to make a complaint.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector saw that the recording and reporting of incidents and accidents that occurred in the centre was monitored by the person in charge and, the service co-ordinator with feedback provided to staff as needed. Based on the records seen incidents were reported to HIQA such as interactions between residents that had a negative impact on them, their safety and quality of life.

Judgment: Compliant

Regulation 34: Complaints procedure

The person in charge advised that there were no open complaints. The six-monthly internal reviews monitored the receipt and management of complaints and, these also stated that no complaints had been received. Residents were consulted with and, did provide feedback that was used to inform the six-monthly reviews. Staff held regular meetings with residents and, the records of these meetings indicated that staff discussed the complaint procedure with residents.

Judgment: Compliant

Quality and safety

As stated in the opening section of this report a sequence of events had combined to impact on the routines and, the quality of life that residents had ordinarily enjoyed. These events had exacerbated a known incompatibility of needs. By the time this inspection was undertaken, there was evidence of the action taken to make life better and safer for residents. However, the provider itself had identified that for as long as the number and needs of the residents living in this house remained unchanged, there was ongoing risk to the safety and well-being of residents.

The inspector reviewed one personal plan and aspects of another. The inspector saw that residents were consulted with, had input into their plan and, the support that was provided. The inspector reviewed a personal outcomes folder that was current. The desired outcomes, who was responsible for supporting the resident to achieve them and, what actions had been taken to date were all clearly documented. Having spoken with the resident, the outcomes and whether to pursue them or not were of the residents choosing. There was evidence of consultation with and input from the MDT, for example, in response to the safeguarding issues in the house, but also in response to the broader assessed needs of the residents such as their mobility, their mental well-being, their nutritional requirements and, their overall physical and medical well-being. These needs and, the support and care to be provided were outlined in the personal plan. Generally, the healthcare plans seen by the inspector were of a good standard but the inspector did, at verbal feedback of the inspection findings, identify scope for improving a falls care plan. The plan needed to be more closely aligned to the falls risk assessment and, clinical recommendations.

Staff monitored resident well-being and communicated to representatives as appropriate, any concerns arising, changes in treatment and, incidents that had

occurred. The commitment to resident well-being was evident in the regular progress notes seen by the inspector where staff, management and, the MDT reviewed individual resident well-being and, the effectiveness of the support provided.

However, as previously referred to in this report the provider had concluded that a purposeful reduction of the occupancy of this house was needed to safeguard residents. There was documentary evidence that staff reported and, sought safeguarding advice on incidents that had occurred. The designated safeguarding officer was available to staff and, was included in the decision-making to reduce the occupancy of this house. Safeguarding matters were reported to the relevant statutory body. There was evidence that residents had good access and good support from other MDT members including the behaviour support specialist and, the psychology team. However, the internal quarterly review of incidents for April to June 2021 reported the occurrence of seventeen negative peer to peer incidents. There were four active safeguarding plans. It was clearly documented that residents were at risk from their peers for as long as the number and mix of residents in the house was unaltered. The safeguarding of residents and to need to address the risk was described in records seen as immediate and urgent.

The inspector reviewed the log of risks and was assured that hazards such as this were identified and assessed, controls were implemented to reduce the risk that presented and, where the residual risk remained high, the risk was escalated in line with provider policy. The need for additional action on behalf of the provider to control this risk is addressed in this report in the context of governance and safeguarding. The suite of risk assessments were specific to the centre and, to the assessed needs of each resident. For example, the risk for a fall and, the risk of leaving the centre without staff knowledge. The person in charge and the service co-ordinator reviewed incidents and accidents that had occurred and corrective actions taken included further referral to the MDT or, more practical matters such as the timely replacement of the heating boiler when concerns arose for its safe functioning.

In response to risk to the safety of residents and others, there were restrictive interventions. An additional restrictive intervention had been introduced in response to a new risk arising when in the service vehicle. While the inspector did not specifically look at the review of the use of such practices, there was a risk assessment in place supporting the use of each notified restriction. The person in charge had oversight of and, was aware of the recently implemented intervention. The residents met with did not present as impacted by restrictions in place. Residents had free access to the front and the rear of the house and, were seen to have access to and to enjoy their cigarettes.

One risk, the risk of COVID-19 and the resulting restrictions had impacted significantly on residents' routines and lives and, had most likely contributed to the deterioration of the safeguarding matters in the house. The service co-ordinator described for the inspector the measures taken to counteract the impact such as the review of staffing and, though not full-time, access to off-site day facilities and outdoor amenities. Some residents accessed day services that were not operated by

the provider and these had yet to resume. There was a semblance of a return to more normal routines such as the return to work mentioned in the opening section of this report and, the resumption of visits to the centre and visits to home. Residents had access to programmes such as gardening and art and a range of on-line activities such as music. The log of risks included a suite of risk assessments to support the safe facilitation of off-site activities while keeping residents safe from the risk of COVID-19.

In addition to these risk assessments there were centre specific preparedness and contingency plans including an isolation plan for each resident if needed. Residents were described as having a good understanding of the risk and how to stay safe and, the person in charge was satisfied that the plans were practicable. If not, for example where a bathroom was shared, an isolation facility was still available.

Some improvement was needed in the oversight of the provider's fire safety arrangements. The inspector saw that the house was fitted with a fire detection and alarm system, emergency lighting, fire-fighting equipment and, doors with self-closing devices designed to contain fire and its products. Staff had completed fire safety training and, staff and residents participated in regular simulated evacuation drills. Staff attendance was monitored and, a good number of staff had so far this year participated in a drill. A resident showed the inspector the fire panel and said that they left the house as soon as the alarm activated. However, the report of the drill undertaken to replicate the night-time scenario indicated an evacuation time that was somewhat longer than what would be desired. Two residents had not responded to the alarm and required active prompting by staff to leave the house. The possibility of this happening was reflected in the resident's evacuation plan and, the importance of good fire safety procedures was discussed with the residents at the house meetings. However, based on the time taken to evacuate, the provider needed to review its evacuation procedure, identify a safe evacuation time for the house and, use this benchmark to monitor the effectiveness of the evacuation procedures and, to identify any action needed to reduce the drill time. The inspector also noted that the space beneath the stairs housed the fire detection and alarm system but was also used to store flammable items.

In relation to the premises the provider had concluded that the house was unsuited to the number of residents accommodated. The inspector saw that the house was of a good standard and, its location facilitated ready access to a range of amenities, to the other house that comprised this designated centre and, to the administration offices where the management team was based. However, the inspector saw how all available space was utilised and, some areas such as corridors and, in particular the kitchen were not spacious and could contribute to flash-points for behaviour as described in notifications submitted to HIQA. A reduction in numbers would provide some additional space that could be used to provide additional recreational, sensory or a quiet space, for the remaining residents.

Regulation 10: Communication

The personal plan included any particular communication supports needed to ensure positive and effective communication. The communication plan reflected a broad understanding of communication such as the impact of individual choices and preferences, the importance of routine and, the role of behaviour in communicating needs.

Judgment: Compliant

Regulation 11: Visits

The process of risk assessment and, reasonable controls supported safe access to family and home.

Judgment: Compliant

Regulation 13: General welfare and development

It was evident that COVID-19 had impacted significantly on residents' lives and daily routines as they lost access to external day services, to a range of activities, volunteering roles and, employment. Records and discussions provided assurance of the measures taken by the provider to reduce the impact on residents and, to ensure that they were out and about and, meaningfully engaged. Staff supported residents to use technology if they wished to remain connected with life and family.

Judgment: Compliant

Regulation 17: Premises

The provider had concluded that the house was unsuited to the number of residents accommodated. The inspector saw that the house was busy and active, all available space was utilised and, some areas such as corridors and, in particular the kitchen were not spacious and could contribute to flash-points for behaviour between residents as described in notifications submitted. A reduction in numbers would provide some additional space that could be used to provide additional recreational, sensory or a quiet space, for the remaining residents.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The personal plan included a plan to support any assessed nutritional needs. The care provided was informed by clinical recommendations and sought to encourage healthy lifestyle choices. Staff monitored resident body weight as an indicator of the effectiveness of the plan. The inspector saw that the preparation of meals was very much part of the routines of the house. A resident said that he enjoyed cooking and baking with staff. Another resident said that he liked the meals that were provided.

Judgment: Compliant

Regulation 20: Information for residents

The residents guide contained all of the required information such as to how to access any inspection reports.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector reviewed the log of risks and was assured that hazards were identified and assessed, controls were implemented to reduce the risk that presented and, where the residual risk remained high, the risk was escalated in line with provider policy. The need for additional action on behalf of the provider to control risk is addressed in this report in the governance and safeguarding sections.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had effective procedures to reduce the risk of the accidental introduction and onward transmission of COVID-19 and, plans to respond to any suspected or confirmed COVID-19.

Judgment: Compliant

Regulation 28: Fire precautions

The report of the drill undertaken to replicate the night-time scenario indicated an evacuation time that was somewhat longer than what would be desired. The provider needed to review its evacuation procedure, identify a safe evacuation time for the house, use this benchmark to monitor the effectiveness of the evacuation procedures to identify any action needed to reduce the drill time. The inspector noted that the space beneath the stairs housed the fire detection and alarm system but was also used to store flammable items.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The personal plan was based on the resident's assessed needs, abilities and preferences. Residents were consulted with and had input into their plan including the plan for pursuing their personal objectives. There was documentary evidence of regular MDT input into the plan itself and, into the review of the effectiveness of the plan in consultation with the staff and management team.

Judgment: Compliant

Regulation 6: Health care

Staff monitored resident well-being and ensured that residents had access to the care, services and, clinicians that they needed for their continued health and well-being.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was evidence of regular consultation with and, support from the relevant MDT members as the provider sought to provide therapeutic support for residents. This support included input from the advanced nurse practitioner in behaviour support, psychiatric review and, very regular input from the psychology team. The positive behaviour support plan was current and, had been regularly reviewed. Staff had completed the required training in responding to behaviour of concern and risk. There was a risk assessment in place for each restrictive intervention that was in

use.

Judgment: Compliant

Regulation 8: Protection

It was clearly documented in a range of records seen by the inspector that residents were at risk of harm from their peers for as long as the number and mix of residents in the house was unaltered. The current arrangements were described as unsustainable and, the need to address it was described as immediate and urgent. It was not however resolved.

Judgment: Not compliant

Regulation 9: Residents' rights

Residents were consulted with and had input into the support provided. It was reported to the inspector that this consultation included any proposed transition from this service so as to reduce the safeguarding risk. Residents raised concerns that were listened to and, staff and management advocated for a better service for residents, such as access to their day service and, resolution of the safeguarding concerns so that each resident's right to a safe home was promoted. Staff met with were noted to respect resident privacy and dignity for example, in seeking resident permission to enter their bedrooms. If permission was not given, this was respected.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Corrib Services OSV-0004858

Inspection ID: MON-0033789

Date of inspection: 24/08/2021

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 23: Governance and management	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>The Person in charge will ensure that the Annual Review for the Designated Centre is carried out in a timely fashion and with relevant consultation and feedback from representatives.</p> <p>Reducing the number of people living in one of the houses the Designated Centre is priority for the team. A transition plan was in place and the transition had commenced for one individual to move but due to a change in circumstances this transition can no longer occur. The Person in Charge will continue work with members of the MDT to look at resolving the safeguarding issues in the Designated Centre and a possible reduction in the numbers living in the Designated Centre.</p>	
Regulation 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <p>In line with Regulation 17 the Person in Charge will work with the team to put a time bound plan in place to reduce the numbers of people living in the house in order to reduce the safeguarding risks.</p> <p>The Team Leader has address the issue of under stairs storage.</p>	

Regulation 28: Fire precautions	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions: The team leader has addressed the issue of storage under the stairs. The team will schedule further night time fire drills between now and the end of the year in order to reduce the evacuation time</p>	
Regulation 8: Protection	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection: The Person in Charge and the MDT will continue to work on reducing the number of residents living in the Designated Centre. They will review each individuals support needs taking into account compatibility and hopefully will be successful in identifying a suitable placement for an individual to move too. This planning process will be person centered and guided by the needs of the people supported. When a suitable placement can be identified a transition plan will be put in place with clear time lines to support the move.</p>	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	31/01/2022
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	31/12/2021
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and	Not Compliant	Orange	31/12/2021

	their representatives.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	31/12/2021
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/12/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/01/2022