



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

Issued by the Chief Inspector

Name of designated centre:	Orchid Lane
Name of provider:	Sunbeam House Services Company Limited by Guarantee
Address of centre:	Wicklow
Type of inspection:	Announced
Date of inspection:	12 January 2022
Centre ID:	OSV-0005052
Fieldwork ID:	MON-0027187

About the designated centre

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

Orchid Lane is a designated centre for people with intellectual disabilities and is operated by Sunbeam House Services Company Limited by Guarantee. The centre is located in a town in County Wicklow. The centre comprises of four single occupancy apartments within a residential complex that also consists of self-directed living apartments and day services. The designated centre currently provides designated centre supports for four adults with intellectual disabilities. The centre is managed by a full time person in charge who shares their role with another designated centre. The person in charge report to a senior services manager who has operational oversight of a number of designated centres and other support services within Sunbeam House Services. Two social care workers support the residents during the day with a walking night staff supporting residents at night time.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3
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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 (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
Wednesday 12 January 2022	09:30hrs to 18:15hrs	Louise Renwick	Lead
Wednesday 12 January 2022	09:30hrs to 18:15hrs	Michael Muldowney	Support

What residents told us and what inspectors observed

Inspectors ensured physical distancing measures and use of personal protective equipment (PPE) was implemented throughout the course of the inspection and during interactions with residents and staff. For example, wearing appropriate face masks, frequently using hand sanitiser and maintaining physical distancing, where possible.

At the time of the inspection, there were three residents living in the designated centre in their own individual apartments, and there was one apartment vacant following a discharge at the end of 2021. The three residents completed written questionnaires with the support from staff, and during the inspection each resident spoke with inspectors and facilitated a visit in their own individual apartment.

The questionnaires received indicated overall that residents were satisfied with their designated centre and the premises and facilities available. Residents answered that they knew how to raise a complaint and felt satisfied that it would be appropriately responded to. Residents outlined in the questionnaires that they were happy with the food and drink available and the choice at mealtimes and overall with the support from the staff team.

The designated centre was made up of four individual apartments in this centre, on site with an apartment operated by another provider and three apartments used by people with self-directed supports who are not a part of the designated centre, a day service workshop and day service communal space with canteen facilities. The premises had numerous entrance points and exit gates around the grounds, which were set within a larger setting with other external companies. The staff office was located in a separate building to the apartments across a courtyard which had benches and was shared with day services and other neighbours. The layout of the premises was not optimal for the supervision of staff, most notably for staff who supported residents in a one to one capacity as apartments were small in size.

The external premises required some upkeep, in particular the thick build up of moss on the roof of the apartments, and external painting of walls, window sills and frames.

Inspectors spoke with two residents within their own apartment, and residents showed inspectors their living space and spoke about their experience living there. Inspectors found that these apartments were decorated tastefully and to the preferences of the resident. Inspectors observed information on COVID-19, complaints and advocacy displayed in the hallway. Residents told inspectors that they were happy with their apartments, the facilities and the space available. Residents also spoke about fire safety and were aware of what to do in the event of the fire alarm activating. In one apartment some painting was required in the kitchen and dining area and it was observed that the self-closing device in on the door leading to the living area was broken. The person in charge informed

inspectors that this has been reported and they were awaiting for it to be repaired. Also in this apartment a resident's washing machine was broken and was due to be fixed. In the mean time, the resident was using alternative laundry facilities on site. The resident had a pet cat who was present during the day and other residents commented that they liked the pet cat and sometimes it came over to their apartment too.

Residents liked their home, and felt they had sufficient input and support from the staff team, but also liked their own space and independence of living alone. The apartments were designed originally for semi-independent living, however some residents' needs had changed over the previous years. In one apartment, a resident showed inspectors that their kitchen was not fully accessible for them, for example they found it difficult to reach items on the top shelf of their presses to access glasses and kitchenware, and had to request staff to come to assist them. Inspectors also noticed that space was limited for this resident, who used mobility aids, in the small kitchen area. In this apartment, it was seen that the resident's bedroom was an inner room, that meant that in the event of a fire or evacuation at night-time, the resident would not have a clear pathway to the only fire exit at the entrance of the apartment. This could pose a risk to the safe evacuation in the event of an emergency.

Residents spoke about enjoying walking around the grounds to help their mobility, going out with staff for longer distances in the car and the contact they maintained with their own families. For example, a resident had spent Christmas period with their siblings and enjoyed their time there. Residents spoke about going on short breaks and holidays, for example hotel stays in Waterford and Cork and how they enjoyed planning these throughout the year.

Inspectors spent a short time in the third apartment with a resident, supported by staff. This apartment was limited in space. The main room consisted of open plan living/dining and kitchen area had been recently painted by a member of the resident's family. It was nicely decorated and comfortable with homely soft furnishings and some shelving that family members had recently installed. The resident had recently got a larger bed in their bedroom and the bathroom had a bath and showering facilities. There was a small dining table and two chairs next to the kitchen area. In this apartment, the fridge and freezer had padlocks in place, and some of the cupboards for dry food storage were also locked. Earlier in the day staff members demonstrated to inspectors with a bunch of keys how they were opened, and the contents within the press and cupboards. The resident's bedroom entered into the main living space of the apartment, which needed to be walked through to get to the only fire exit in the apartment. This posed an additional risk for the safe evacuation in the event of fire at night-time.

During the inspection, inspectors spoke with some family members of residents to gain their views and opinions of the care and support delivered in the designated centre. Family members spoke about inconsistency in staffing in the previous months, and the impact that they felt this was having on the quality of the care and support provided to their relatives. For example, less person-centred care and impact on personal care and laundry. Family members discussed the use of

restrictions in their relatives apartment and questioned the justification of some of these, which they felt were limiting their relatives abilities to be more independent and develop their own skills. Family members also discussed that they had raised concerns or complaints in the past, some of which were not addressed to their satisfaction, but others which had plans in place by the provider for addressing. For example, access to day services.

During the day, some residents were out for different appointments with the support of staff, some residents were walking locally and others where in their day service provided externally off site. Residents liked to come together on Sundays to have their dinner meal together with support from staff. Due to the size of individual apartments, this meal was cooked and served in an adjacent canteen room that is operated by the provider's day service. Overall residents enjoyed their home and their own space, and were happy with their daily and weekly plans and activities. One resident had not yet returned to external day services since COVID-19, and they and their family were eager for them to return. This had been raised through the complaints process also, and the provider had hired a new staff member who would be responsible for supporting this resident to attend their day service when they wished.

On the day of inspection, as as per the written rosters there were two staff working during the day time from 9am to 9pm. One staff worked each day to support one resident during the day and the other staff member provided support for two semi-independent residents. The designated centre had access to a centre vehicle for transport. At night time, there was one waking night staff on duty, who was based in the staff office across the courtyard and responded to any calls or requests from residents during the night. Staff at night time also monitored a door alarm to alert them to a resident leaving their apartment.

Overall, residents were satisfied with their living environments and the support they received from the staff team, however some improvements were required in relation to ensuring the premises and the aim of the designated centre could fully support the current and future needs of residents.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

The purpose of this inspection was in response to the provider's application to renew the registration of the designated centre. Some improvements were required in relation to clearly identifying the aims of the designated centre and the services and supports that could be delivered within the design and lay-out of the premises. The centre was originally designed as a centre for semi-independent living, provided in individual apartments with on-site support from a staff team. Since the previous

inspection there had been a number of adverse events including peer to peer safeguarding incidents, incidents of escalated behaviour and a recent emergency discharge. There had also been changes to the management personnel and periods of instability in staffing resources.

The provider has prepared an up to date and written statement of purpose for the designated centre that contained the information set out in Schedule 1 of the regulations. A copy of the statement of purpose was available to residents and their representatives.

The provider had put in place a clear management structure to be responsible for the operational management of the designated centre. There was a newly appointed full-time person in charge who had taken up post in December 2021, who reported to a recently appointed senior services manager, who in turn reported to the Chief Executive Officer. These management changes in personnel had been notified to the Chief Inspector, as required. The person in charge was found to be suitably skilled, qualified and experienced.

Along with a clear management structure for lines of reporting and responsibility, there were oversight systems in place by the provider. For example, the person in charge had a local system of audit, review and checks to oversee the care and support delivered in the centre. There were established lines of escalation and information to ensure the provider was aware of how the centre was operated and if it was delivering a good quality service. There had been unannounced visits completed through the quality department, on behalf of the provider on a six month basis, along with an annual review on the quality and safety of care. There was also audits completed on areas such as 'personal profiles', 'staff knowledge', 'health and safety', and 'house keeping'. Meetings were planned between the person in charge and senior manager on a monthly basis to review the care and support in the designated centre, this had not yet occurred as the person in charge was only recently in post.

While there was a clear structure and oversight systems put in place by the provider, the information gathered through adverse events such as accidents, incidents and behaviour events was not fully informing these oversight and review systems to continuously improve on the quality of care delivered. Information gathered from these events were not being effectively reviewed to identify patterns or trends, or to adequately identify new or emerging risks. For example, at times some residents required transfer to alternative locations based on their health needs and increased support requirements, there had also been a recent emergency discharge for a resident out of the designated centre. However, these events did not result in the provider reviewing the likelihood of this happening again for other residents, and to explore control measures to reduce the risk and potential impact this could have.

A directory of residents was maintained in the designated centre. The directory required enhancement as it did not contain discharge or transfer details of previous residents, and contained information on people who were not residing in the

designated centre.

The provider had identified the staffing requirements for this designated centre, as outlined in their statement of purpose. The staff team consisted of a team social care workers, with two staff working from 09.00 to 21.00 each day, and one staff working a waking night shift from 21.00 to 09.00 each night. While there was agreed staffing resources based on the needs of residents, there had been periods of time in recent months where there were vacancies and absenteeism of staff members which had resulted in a high amount of temporary agency staffing working in the centre to cover these shifts. This was having an impact on the consistency of care and support for residents. For example, residents were not always being supported by staff who knew them well and their support needs. While the provider had ensured an adequate number of staff were on duty to support residents, continuity of care was impacted due to the temporary staffing cover in place.

Similarly, while there was an adequate number of staff available to work in the centre, some roles were not fully supportive of the needs of residents. The provider had identified these issues and had plans in place to address them. For example, a new role of instructor had been recruited for and a staff member was due to start in the coming weeks, and a familiar staff employed by the provider was returning to post after leave. The person in charge had maintained planned and actual staff roster however, improvements were required as a sample of rosters reviewed by inspectors did not include the full names and titles of all staff members, most notably temporary agency staff.

There was oversight of the training needs of staff, and training needs were identified in advance and planned for by the person in charge. While an oversight system was in place, there were gaps in refresher training for staff in certain key areas identified by the provider. Staff members had completed relevant training in areas such autism awareness, fire safety, safe administration of medicines, safeguarding residents from abuse, hand hygiene, and COVID-19. Staff also completed training in the management of aggression and restrictive practices, however, on the day of inspection several staff members were overdue refresher training in these areas. The person in charge expressed that there was challenges in delivering this training due to the COVID-19 pandemic, however, training had been scheduled for the outstanding staff in the coming weeks.

There was a system in place for formal supervision of individual staff members, in line with a guiding policy. The layout and design of the premises, were also not optimal for informal supervision of the care and support being delivered by the the staff team. For example, staff entered individual apartments to offer support to residents, which were limited in size.

Staff team meetings were taking place monthly and the most recent meeting was attended by the new person in charge. Inspectors reviewed a sample of the team meeting minutes and found them to be comprehensive with items such as residents needs, incidents, complaints, risks, staffing, and health and safety discussed.

There were processes in place for the reporting and management of complaints.

Residents and their representatives were aware of the processes and their was information on the complaints available in a user-friendly format. Inspectors found that complaints were recorded by staff as they were reported, and were reviewed by a local complaints officer. Information on complaints was maintained including on the actions taken to address the complaints and if the complaint was satisfied with the response to the complaint. Not all complaints were resolved to the satisfaction of complainants and the time of the inspection, however, the provider had taken actions to address them.

Overall, the provider demonstrated that they had capacity and capability to operate the designated centre in a manner that resulted in positive experiences for some residents, however improvements were required to ensure all information gathered from adverse events was being used effectively to manage risk and prevent further incidents.

Regulation 14: Persons in charge

The provider had appointed a full-time person in charge to hold responsibility for the designated centre. The person in charge was suitably skilled and experienced in their role. The person in charge had responsibility for two designated centres, and had support from a deputy manager to ensure the effective operational management of both. While the person in charge mostly met the requirements of the regulations, and had a primary degree in a relevant area the provider had not submitted evidence that they held a suitable qualification in management.

Judgment: Substantially compliant

Regulation 15: Staffing

While the provider had ensured an adequate number of staff were working in the centre during the day and night time, there had been patterns of inconsistent staffing in previous months, with vacancies and staff leave being covered by temporary agency staffing. This was impacting on the consistency of care and support available for residents, most notably for residents who required familiar staff and set routines.

The provider was in the process of recruiting a staff member to work in the designated centre for a particular role in line with residents' needs, and a familiar staff employed by the provider was due to return to their post.

The person in charge maintained actual and planned staff rosters to demonstrate who was working in the designated centre throughout the month. However, these records did not include the full names and titles of all staff members, most notably

temporary agency staff.

There were routine staff meeting happening in the designated centre, with clear agendas to promote consistent practice.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had access to appropriate training, including refresher training. The person in charge had oversight systems in place to identify the training needs of the staff team, the impact of national restrictions and requirement for social distancing measures had impacted on the delivery of certain training for staff members. Some staff members were out of date with refresher training in certain areas at the time of the inspection.

There was a system in place for formal supervision of individual staff members, in line with a guiding policy. The layout of the premises were not conducive to the informal supervision of staff carrying out their duties.

Information on the Health Act 2007 (as amended), regulations and standards were available in the designated centre.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory did not detail discharge or transfer details of previous residents, and the directory of residents contained information on people who were not residing with a designated centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had put in place a clear management structure and lines of reporting, accountability and responsibility within the designated centre. Recent changes to management personnel had been notified to the Chief Inspector.

The provider had management and oversight systems in place such as auditing and review schedules, monthly governance meeting and quarterly incident reviews. The

provider had carried out an annual review of the centre for the previous year, and had ensured unannounced visits to the centre were completed on a six-month basis.

While there was a clear structure and management systems in place, the provider was not using information gathered from adverse events, behaviour incidents and other events to continuously improve the quality of the care delivered, and to ensure any new or emerging risks were identified and managed.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose for the designated centre included all of the required information set out in Schedule 1 of the regulations. The statement of purpose was available to residents and their representatives, and was reviewed and updated as required.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had provided an effective complaints procedure for residents that was in an access format, and included an appeals procedure. The complaints procedure was displayed in the designated centre, and residents and their families were aware of it. All complaints were reported and escalated to the local complaints officer for review. Records were maintained on the outcome of complaints made, the actions taken, and the satisfaction of the complainant. While not all complaints were resolved to the satisfaction of the complainants, the provider had taken actions to address complaints.

Judgment: Compliant

Quality and safety

While the provider had systems and supports in place to meet and care and wellbeing needs of residents, improvements were required to ensure that residents were in receipt of a full quality and safe service.

The designated centre is located close to many local amenities and services. The premises, as described in section one of the report, consisted of four apartments

situated on a busy campus-like environment. The four apartments are the same building as other apartments operated by the provider and another provider. There was also a day service and offices on site. There were three residents living in the centre requiring varying levels of needs. Residents told inspectors that they liked living in their apartments. The apartments were tastefully decorated and to residents preferences. While the centre suited the needs of some residents, further consideration was required by the provider to ensure that the accessibility, lay out , and service delivery in the centre can fully meet the current and future needs of all residents living there.

The apartments were small and limited in space which posed a challenge for residents to effectively utilise, for example the kitchen area of one apartment did not provide enough space for a resident to easily move around and they could access all areas of their kitchen such as presses. This hampered the residents independence within their home. The limited space also impinged on residents ability to have visitors for meals or social gatherings. The three residents had a weekly Sunday dinner together which took place in the communal area of the day services as their was limited space in their own apartments. The exterior premises required attention and upkeep, for example, the roof was covered in moss and painting was required for the exterior walls, window sills and frames, resulting in a worn and uninviting appearance. Minor painting work was also required in one residents apartment.

Staff were observed wearing appropriate face masks and adhering to social distancing precautions. The provider and person in charge had put in place measures to reduce the risk of infection in the centre, however, enhancements were required. There were policies, guidelines and procedures available to staff relating to infection prevention and control, and COVID-19. There was also easy to read and accessible information for residents on COVID-19. There was also information available from public health, however, not all of the guidance was up to date such as the guidance on visitors. This presented a risk of staff not adhering to the most up to date guidance. Visitor temperature checks and questionnaires were taking place to prevent the spread of COVID-19 into the centre. There was an adequate supply of personal protective equipment (PPE) which was stock checked weekly. There was a suite of risk assessment conducted in relation to COVID-19, as well as individual resident risk assessments and isolation plans. The COVID-19 self assessment tool issued by Chief Officer and the centres 'monthly' COVID-19 audit were last completed in March 2021, and were in need of review.

The provider had put in place measures and procedures to prevent and manage fire in the centre. There was suitable fire prevention and fighting equipment in place such as fire doors, detection and alarm system, emergency lighting and fire extinguishers. Records of servicing these equipments were well maintained. In one apartment, the self closing device on a fire door was damaged compromising the fire containment measures in place. Residents spoken with were aware of what to do in the event of a fire. Staff had completed fire safety training and were completing daily, weekly and monthly fire checks. Residents had individual evacuation plans to guide staff on supports that residents required in the event of a fire or emergency. The person in charge had a schedule of fire drills including night time drills. Fire drills had also been completed with reduced staffing to demonstrate

that all residents could be safely evacuated with the support of one staff member. The centres written fire evacuation plan was undated so it could not be determined if it was up to date. In three of the four apartments, the layout of the apartments posed a potential risk to residents in safely evacuation in the event of a fire emergency as there was only one fire exit, which was at the entrance door. The provider had not demonstrated that an adequate means of escape was provided for these apartments where inner rooms were being used as bedrooms.

There was policies and procedures in place for the identification, assessment and management of risks. The persons in charge and staff team had completed assessments on the risk presented in the centre and there was associated plans. Incidents were recorded on the providers information management system. However, improvements were required in the learning and trending of information from incidents to ensure that similar events could be appropriately planned for such as the emergency discharge of a resident. A recent crisis transition had not taken place in a planned manner. The provider had developed a policy on the transfer and discharge of residents; however, the details on emergency transitions was lacking and there were no contingency plans in the event of a crisis transition.

There was vehicle available to the centre that was appropriately taxed, insured and serviced.

While residents had access to assessments of their needs while living in the designated centre, these were focused on the supports that could be delivered with the current layout, design, staffing and purpose of the centre itself. For example, comprehensive behaviour support plans, mobility assessments and personal plans based on the supports required in this location. However, the assessments of need did not consider the environmental factors, or limitations of the environment. For example, some residents required one to one staffing for large periods of the day and received this within an environment that was designed for semi-independent living. For residents who had mobility needs, and had the potential to see a decline in their mobility the provider had not assessed the long-term suitability of the environment for residents over the course of the next number of years. While the provider had assessed, planned for and increased and adapted supports for residents in this location, they had not considered the impact of the environment on residents' current or future needs. This resulted in a risk to residents, that their residential placements and home would no longer be suitable, or that an emergency discharge or transfer may be required in a crisis manner without effective planning and measured time frames.

Plans were developed and implemented for residents' health care needs. Residents had access to allied health and social care professionals such as occupational therapy and psychology, and were supported to avail of National Screening Services, if they wished or consented to this.

The provider had prepared policies on positive behaviour support and restrictive practices to guide staff practice. Training was also provided to staff in the areas of management of behaviour of concern and on restrictive practice, however, on the day of inspection, several staff members were overdue refresher training in these

areas.

There were several rights restrictions implemented in the centre which impacted on two residents. In one apartment, there was a locked press and a fridge to limit a resident's free access to certain foods. Inspectors observed the impact of this restriction on the resident, when a staff member was asked to open the press for the resident to access tea bags while their family members were visiting. The staff member opened the press using a key on a bunch of keys. Inspectors also observed locks on the resident's fridge and freezer. These restrictions were not deemed to be the least restrictive option and required further consideration and assessment of a justified rationale for use. In another apartment, one press was locked to limit the resident's access to certain foods. The resident spoke to inspectors about the locked press and said they understood the rationale for the restriction and were happy for it to be implemented.

Residents engaged in activities of their choice independently and with the support of staff. Residents enjoyed activities such as walking, eating out, watching television, shopping, visiting family, going on hotel breaks, and attending day services and social clubs. The residents were observed to be supported in exercising choices in relation to their meals, outings, and day to day life. One resident regularly attended a day service independently and told inspectors that they enjoyed their activities there. In addition, the resident was also very active in the evenings and at weekends and told inspectors that they enjoyed availing of activities in their community such as social clubs. One resident had not returned to day services since the pandemic started despite expressing wishes to return. Instead the resident was supported by a staff member to engage in social and personal activities. The provider has secured staffing due to commence in the coming weeks to support the resident to return to their day service. The third resident spoken with, does not attend a day service out of choice and mostly partook in activities of their choice in the centre independently, however was reliant on staff and transport to leave the grounds of the centre due to their mobility.

The provider had developed a policy and clear procedures on the safeguarding of residents from abuse. The policy was available to staff members and staff members spoken with were familiar on the safeguarding procedures implemented in the centre. Residents had received information on safeguarding and advocacy and safeguarding passports were developed for all residents to help them to understand.

Regulation 13: General welfare and development

The registered provider had provided residents with care and support in accordance with their wishes and preference, however, aspects of the support were not satisfactory to residents. One resident was keen to return to their day which had been suspended at the start of the COVID-19 pandemic. The resident's return to day services was dependant on the provision of an additional staff member who

although recruited had not commenced working in the centre yet.

Judgment: Substantially compliant

Regulation 17: Premises

The provider had not ensured that the layout of the premises fully met the aims and objective of the service or residents as some areas of the premises were not accessible to residents such as the kitchen in one apartment. In addition, the apartments were limited in space. The limited space impinged on the ability to supervise staff where appropriate and for residents to accommodate visitors.

Repair of a washing machine and fire door closing device was required in one apartment.

The external premises were aesthetically unpleasing as there was moss build up on the roof and exterior painting was required. Painting was also required in one apartment.

Judgment: Substantially compliant

Regulation 25: Temporary absence, transition and discharge of residents

The policy on the transfer and discharge of residents developed by the provider, did not include sufficient detail on emergency transitions to guide effective emergency transitions of residents, should this occur. A recent crisis discharge while safely managed was not done in a planned manner and did not ensure residents' need were appropriately met while they were in alternative accommodation.

There was no contingency plans in place should residents require an emergency discharge due to incidents or change in wishes or needs.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

While the provider had policies and systems in place for the assessment, control and review of risk, not all risks had been sufficiently identified, considered and comprehensively assessed. Most notably risks in relation to individual residents which could have an impact on their residential placement and/or and their future needs. For example, the risk of emergency discharge, risk of inconsistent staffing

and the impact of this on residents' supports.

While residents were encouraged to manage their own medicine and their capacity had been assessed in this regard, the risks associated with self-medicating had not been formally assessed, for example, to include the likelihood of risk based on review of medication errors or mistakes and to identify any additional measures or learning that may be required.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had implemented policies and procedures to control the risk of healthcare associated infections in the designated centre. Practices on the day were seen to be promoting of infection prevention and control, for example the correct use of personal protective equipment and identified procedures for how to manage a suspected or confirmed infection.

There was adequate supplies of PPE available in the centre for staff to use, and residents had been informed and kept up to date with measures to keep themselves safe in relation to COVID-19.

Where there were guiding policies and procedures and an overall risk assessment document completed for the risk of COVID-19 these had not been updated since March 2021, similarly monthly audits in relation to COVID-19 had not been completed since March 2021. This could impact on the provider's response should an infection risk occur.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Staff had completed training in fire safety and were completing daily, weekly, and monthly fire checks. There was a schedule of fire drills and fire drills had taken place to demonstrate that residents could be safely evacuated.

On the day of inspection the self-closing device on a fire door was broken compromising the centres fire containment measures.

Individual evacuation plans had been prepared for residents to guide staff practice in the event of a fire. The fire evacuation plan was undated so could not be determined if it was up to date.

Each of the apartments, had one fire exit which was the front door. In three of the

four apartments, the provider had not demonstrated that an adequate means of escape was provided for residents where inner rooms were being used as bedrooms.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

There was a system in place to assess residents' health, social and personal needs in the designated centre and these documents were reviewed regularly and included input from allied health professionals, where appropriate. Where a need had been identified, there was a written personal plan in place outlining how each resident would be supported. For example, short-term health plans or mobility plans. Residents' aspirations and wishes in relation to their personal and social goals were assessed and outlined in written plans.

While residents' needs within the designated centre were assessed and well documented, the provider and person in charge had not considered the impact of the environment on the delivery of good quality care and support and to determine the suitability of the centre for the purposes of meeting the needs of each resident.

Judgment: Not compliant

Regulation 6: Health care

Residents were provided with appropriate health care as outlined in their personal plans.

Residents had access to their own general practitioner (GP) along with access to other health and social care professionals through referral to the primary care team, or to professionals made available by the provider.

Advice or recommendations from health and social care professionals was incorporated into residents' personal plans, and put into practice by the staff team.

Residents were supported to avail of National Screening Services, if they chose to.

Judgment: Compliant

Regulation 7: Positive behavioural support

Staff members required refresher training in the management of aggression and

restrictive practices to ensure that the practices in the centre were based on best practice.

The provider had not ensured that the use of restrictive practices were applied with national policy and evidence based practice. It was not demonstrated that the use of restrictive practices were effectively reviewed and considered to ensure that they were the least restrictive or upheld residents rights.

Judgment: Not compliant

Regulation 8: Protection

The provider had ensured there were policies, procedures in place to identify, report and respond to safeguarding concerns in the designated centre. There was an identified designated officer for the designated centre, to support the management of any safeguarding concerns or allegations.

Safeguarding concerns or incidents had been recorded and reported in line with National policy, and safeguarding plans put in place to promote residents' safety when incidents had occurred.

Residents were supported to develop knowledge and understanding needed for protection from abuse. Staff had received training in the safeguarding of residents and were familiar with the providers policies and procedures on safeguarding.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were supported and promoted to make decisions and exercise choices in their daily lives, and their preferences were respected. Residents were consulted with and participated in the organisation of the centre.

There was information available to residents on advocacy services.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Substantially compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 25: Temporary absence, transition and discharge of residents	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Orchid Lane OSV-0005052

Inspection ID: MON-0027187

Date of inspection: 12/01/2022

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 14: Persons in charge	Substantially Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: <ul style="list-style-type: none"> The PIC commenced Management training course on 27th April 2022. 	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: <ul style="list-style-type: none"> New full-time Deputy Client Services Manager appointed Feb 18th, 2022 Experienced full-time staff member returned from long term leave 14th Jan 2022 1.7 WTE staff currently been recruited. New staff member commenced role to support resident in line with their needs. Full names and titles of all staff now present on roster. Recruitment for 1 x 169 CSW has been appointed and induction is due to start in the coming weeks. 1 x Instructor/Supervisor 100hr contract – still outstanding. 	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	

All mandatory refresher training will be completed by 31st May 2022. Restrictive practice and Safety Intervention training now complete for all staff.

Additional therapeutic activities outside the apartment space, are now being offered to clients now that Covid restrictions have eased. This will allow for closer supervision of staff when doing other activities. The PIC/Deputy Client Services Manager will continue to conduct one to one sessions with the residents to discuss their will and preference.

Please revert to Feedback reg 16 regarding formal supervisions.

Regulation 19: Directory of residents	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 19: Directory of residents:
Name of resident identified by HIQA on the day of inspection has now been removed from the directory of residents and is no longer attached to the designated centre.

Directory of residents has been updated. Central Information Database (CID) has a location report which provides information on current service users and staff and also provides names and departure dates of previous residents.

Regulation 23: Governance and management	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 23: Governance and management:
Quarterly reviews are now complete and quarterly oversights will continue by PIC and PPIM at the end of every quarter to ensure all new or emerging risks are identified and managed.

SHS Referral Committee to address current policy on Referral, Entry, Transfer and Discharge regarding emergency accommodation.

Recruitment of 169 now completed. Roster changes have been implemented to ensure continuance of 1:1 support for resident in line with their needs. New DCSM also continues to support said resident on a 1:1 basis regularly throughout the week.

A Deputy Client Service Manager has now been appointed on the 18th February 2022.

A full-time staff member has returned from leave on the 14th January 2022 providing more stability to the roster.

Staff roster now includes full names and titles for all staff including any agency or relief on roster.

All mandatory refresher training was completed by 25.04.2022.

Additional therapeutic activities outside the apartment space, are now being offered to clients now that Covid restrictions have eased. This will allow for closer supervision of staff while facilitating these activities. The PIC/Deputy Client Services Manager will continue to conduct one to one sessions with the residents to discuss their will and preferences around their ADL's and their participation in therapeutic activities. Taylor Activities Committee is now in place which will provide additional oversight from PIC to staff as well sourcing and discussing/sourcing therapeutic activities for clients.

Please revert to Feedback form under Reg 23: Governance and Management regarding supervisions.

Regulation 13: General welfare and development

Substantially Compliant

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

New experienced and trained staff member commenced within the service on the 17th of January 2022 and continues to support resident three days per week to attend their day service. This staff member became DCSM for location, but continues to support resident 3 days per week until additional 100hr staff member is recruited.

Regulation 17: Premises

Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

At a staff meeting dated 21st February 2022 all staff were reminded and it was reiterated by the PIC that in line with health and safety, no items should be placed on the shelf in the kitchen, that maybe out of the resident's reach.

Please see Feedback for Reg 17 regarding limited space.

Additional therapeutic activities outside the apartment space, are now being offered to

clients now that Covid restrictions have eased. This will allow for closer supervision of staff while facilitating these activities. The PIC/Deputy Client Services Manager will continue to conduct one to one sessions with the residents to discuss their will and preferences around their ADL's and their participation in therapeutic activities.

Washing machine repaired and working. Completed.

New Fire door closer has been fitted. Completed.

Required painting of identified room in one apartment by HIQA will be painted by April 2022. Completed.

Exterior walls were power washed on exterior premises. The interior courtyard was treated for moss removal.

Low incline ramp was installed at step of the apartment to support client with mobility issue. Completed.

Regulation 25: Temporary absence, transition and discharge of residents	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 25: Temporary absence, transition and discharge of residents:
SHS Referral Committee to address current policy on Referral, Entry, Transfer and Discharge regarding emergency accommodation.

Discussions will take place in consultation with the resident to transition to a more suitable apartment in the designated centre, should there be a decrease in their mobility.

Works have been completed on identified apartment to support client mobility issues.

Regulation 26: Risk management procedures	Not Compliant
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Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
SHS Referral Committee to address current policy on Referral, Entry, Transfer and Discharge regarding emergency accommodation.

This will ensure risk management procedures are followed and are embedded into practice.

Discussions will take place in consultation with the resident to transition to a more suitable apartment in the designated centre, should there be a decrease in their mobility.

- New full-time Deputy Client Services Manager appointed Feb 18th, 2022
- Experienced full-time staff member returned from long term leave 14th Jan 2022
- 1.7 WTE staff currently been recruited.
- New staff member commenced role to support resident in line with their needs.
- Full names and titles of all staff now present on roster.

A robust Risk assessment is now in place to review any medication errors, identify any additional measures or learning regarding a self-medicating resident.

Regulation 27: Protection against infection	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 27: Protection against infection:
A Self-Assessment Tool is now complete and in place with oversight from PIC and review dates of the self-assessment tool are recorded for end of March, June, September and December 2022.

Monthly Covid audits are completed by nominated staff and reviewed and signed off by the PIC.

Regulation 28: Fire precautions	Not Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:
New closer fitted on fire door. Completed.

Visual floor plans of apartments have been updated to highlight route to exit and are in place in all apartments.

Fire evacuation plan reviewed and dated.

Works have been completed in one apartment to remove inner bedroom concern. An updated floor plan has been sent.

In one apartment route from inner bedroom to exit was noted as an issue of concern in the event of a fire due to obstructions. The layout of the living room area has been modified to ensure clear route to exit area.

In final apartment costing have commenced to remove inner bedroom issue.

All PEEPS for residents have been updated. Two areas of concern regarding deep sleep were identified following the update. Vibrating pillow pads were installed in two apartments to address this concern.

Resident with mobility issues is now fully supported for all evacuations.

Regulation 5: Individual assessment and personal plan	Not Compliant
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Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Some resident's needs have changed, Senior Management Team is actively reviewing other suitable designated centres/service providers and community services to support the residents.

Mobility issues were addressed through changes to inner room issue and the addition of a ramp at front step. Shelf concern was addressed by CSM to all staff in staff monthly meeting. Resident changing needs continue to be monitored.

Regulation 7: Positive behavioural support	Not Compliant
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Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Safety Intervention Training will be completed by SHS on 22nd April 2022 for all staff members. Restrictive Practice training is booked and scheduled to take place on the 25th April 2022.

Some restrictions were put in place under clinical advice, and in the interest of client's health and wellbeing. Resident now has access to a small personal fridge in their apartment. SHS's Behavioral Support Specialist is continuing to support the resident and staff team by providing learning and understanding around in regards to a healthy

relationship with food and beverages. Freezer rights restriction is being addressed on a trial basis currently.

Resident expressed a wish to have some food locked away due to their OCD tendencies and subsequent bouts of ill health due to overeating. SHS recognizes this as a rights restriction despite it being the clients wish and preference. SHS are continuing to educate and support resident to build a healthier relationship and understanding about food.

All rights restrictions are reviewed annually by Client Services Manager, Senior Services Manager and SHS Human Rights Committee.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	17/01/2022
Regulation 14(3)(b)	A person who is appointed as person in charge on or after the day which is 3 years after the day on which these Regulations come into operation shall have an appropriate qualification in health or social care management at an appropriate level.	Substantially Compliant	Yellow	26/04/2022
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances	Substantially Compliant	Yellow	17/01/2022

	where staff are employed on a less than full-time basis.			
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	13/01/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	25/04/2022
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	21/03/2022
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.	Substantially Compliant	Yellow	13/01/2022
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound	Substantially Compliant	Yellow	18/04/2022

	construction and kept in a good state of repair externally and internally.			
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He, she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Substantially Compliant	Yellow	12/04/2022
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	13/01/2022
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	25/04/2022
Regulation 25(4)(b)	The person in charge shall	Substantially Compliant	Yellow	30/09/2022

	ensure that the discharge of a resident from the designated centre take place in a planned and safe manner.			
Regulation 25(4)(c)	The person in charge shall ensure that the discharge of a resident from the designated centre is in accordance with the resident's needs as assessed in accordance with Regulation 5(1) and the resident's personal plans.	Substantially Compliant	Yellow	01/10/2022
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	30/09/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for	Substantially Compliant	Yellow	30/09/2022

	responding to emergencies.			
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	13/01/2022
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	14/04/2022
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	27/11/2022
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	27/11/2022
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet	Not Compliant	Orange	19/01/2022

	the needs of each resident, as assessed in accordance with paragraph (1).			
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	12/04/2022
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	25/04/2022
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	16/03/2022
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive	Not Compliant	Orange	09/05/2022

	procedure, for the shortest duration necessary, is used.			
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