Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Dun Aoibhinn Services - Cashel
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Tipperary
Type of inspection:	Short Notice Announced
Date of inspection:	28 April 2021
Centre ID:	OSV-0005060
Fieldwork ID:	MON-0028319

About the designated centre

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

Dun Aoibhinn Services - Cashel is a designated centre operated by Brothers of Charity Services Ireland CLG. The designated centre provides community residential care for a maximum of twelve adult residents, both male and female, with intellectual disability. The centre consist of two individual purpose-built bungalows which are located next to one another in a town in Co. Tipperary. The first house is a bungalow which provides a community residential care to six adults with a disability. Similarly, the second house is a bungalow which provides community residential care to six adults with a disability. Both units were similar in their design and layout and comprised of a sitting room, kitchen, dining room, an office, six individual bedrooms, staff sleepover room, visitors room and a number of shared bathrooms. Both houses have large well maintained gardens. The centre is staffed by a person in charge, enhanced nurse practitioners, social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	11

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 28 April 2021	10:15hrs to 16:00hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

In line with infection prevention and control guidelines, the inspector carried out this inspection in line with public health guidance and HIQA enhanced COVID-19 inspection methodology at all times. The inspector carried out the inspection primarily from one location in one of the houses of the designated centre. The inspector ensured physical distancing measures and the use of personal protective equipment (PPE) were implemented during interactions with residents, staff and management over the course of this inspection.

From what residents communicated with the inspector and what was observed, it was evident that the residents received a good quality of care and enjoyed a good quality of life.

The inspector had the opportunity to meet with seven residents during the course of the inspection, albeit this time was limited. On arrival to the centre, the inspector was warmly welcomed by one resident while others were observed having breakfast or preparing for their day. Over the course of the inspection, residents were observed accessing their community and spending time in the sitting room relaxing, watching TV and receiving a foot massage. Residents also spent time in the dining room playing board games and having meals and drinks. The inspector had the opportunity to spend time with one resident from the second house in their garden and spoke with them about their views of the service, family and interest in music. They spoke positively about the staff team and the care and support they received.

In addition, seven residents completed a questionnaire describing their views of the care and support provided in the designated centre. Overall, these questionnaires contained positive views and indicated a high level of satisfaction with many aspects of service in the centre such as activities, bedrooms, meals and the staff who supported them. In addition, the questionnaires noted the negative impact of the public health restrictions for residents in relation to community outings and visiting people important in their lives.

The inspector observed the staff team treating the residents with respect and dignity. All communication observed between the residents and members of the staff team was seen to be respectful and appropriate to the residents' communication needs. Positive friendly interactions were observed between the staff team and residents. Residents were supported to stay in contact with people important in their lives through video calls, sending cards and photos.

The designated centre comprised of two houses which were purpose built and, in general, the houses presented in a clean, well-furnished and homely manner. On the day of the inspection, the inspector visited one house of the designated centre and observed equipment being serviced by an external contractor. However, there were areas of paint in the centre which required upkeep. This had been self-

identified by the provider.

In summary, based on what residents communicated with the inspector and what was observed, the inspector found that the residents received a good quality of care and enjoyed a good quality of life. However, there are some areas for improvement including restrictive practices, staff training and development, premises and personal plans. The next two sections of the report present the findings of this inspection in relation to the the overall management of the centre and how the arrangements in place impacted on the quality and safety of the service being delivered.

Capacity and capability

There were management systems in place to ensure that the service provided was safe, consistent and appropriate to residents' needs. There were appropriate management systems in place to monitor the care and support being delivered. On the day of inspection, there were sufficient numbers of staff to support the residents' assessed needs. However, improvement was required in the area of staff training and development.

There was a clearly defined management structure in place. The centre was managed by a full-time person in charge who was responsible for the management of the two houses of the designated centre. The person in charge demonstrated a good knowledge of the residents and their needs. There was evidence of regular quality assurance audits taking place to ensure the service provided was safe, effectively monitored and appropriate to residents' needs. These audits included the annual review for 2020 and the provider unannounced six monthly visits as required by the regulations. The quality assurance audits identified areas for improvement and action plans were developed in response. From a review of a sample of actions, it was evident that the actions had been completed in a timely manner.

The person in charge maintained a planned and actual roster. A review of rosters demonstrated sufficient staffing levels and skill mix to meet the residents' needs. At the time of the inspection, the centre was operating with a .26 whole time equivalent (WTE) nurse vacancy. This vacancy had been filled by a regular staff member and the inspector was informed that the provider was actively recruiting to fill this vacancy. Continuity of care was maintained by covering shifts with the existing members of the staff team and the use of regular relief staff. Throughout the inspection, staff were observed treating and speaking with the resident in a dignified and caring manner.

There were systems for the training and development of the staff team. The inspector reviewed a sample of staff training records and found that a number of the staff team required refresher training in areas including de-escalation and intervention techniques, fire safety and safeguarding. This meant that they did not have up-to-date training to meet the needs of the residents. This had been self-identified by the provider and the inspector was informed that the delays in

scheduling refresher training were due to the impact of COVID-19.

In addition, the previous inspection identified that the majority of the staff team had not been provided with specific training related to residents' needs. There was evidence that a number of the staff team had undertaken training in specific training related to resident needs. However, some improvement was required to ensure all staff could avail of specific training as required.

Regulation 14: Persons in charge

The person in charge was suitably qualified and experienced. The person in charge worked in a full time role and demonstrated a good understanding of residents and their needs.

Judgment: Compliant

Regulation 15: Staffing

There was sufficient staffing levels and skill mix to meet the residents' needs. Continuity of care and support was maintained by covering shifts within the existing members of the staff team and the use of regular relief staff.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems in place to monitor staff training and development. However, refresher training was not up-to-date for a number of staff members in areas including fire safety, safeguarding and de-escalation and intervention techniques. In addition, some improvement was required to ensure all staff could avail of specific training specific training related to residents' needs as required.

Judgment: Not compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. There was evidence of regular quality assurance audits taking place to ensure the service provide was safe,

effectively monitored and appropriate to residents' needs. The audits identified areas for improvement and action plans were developed in response.

Judgment: Compliant

Regulation 31: Notification of incidents

Incidents and accidents occurring in the centre were appropriately notified to the Chief Inspector as required by Regulation 31.

Judgment: Compliant

Quality and safety

Overall, the management systems in place ensured the service was effectively monitored and provided safe, appropriate care and support to the residents. However, some improvements were required in the personal plans, premises and restrictive practices.

Each resident had an assessment of health, personal and social care needs in place. The assessments informed the residents' personal support plans which were up-to-date and suitably guided the staff team in supporting the resident with their assessed needs. However, one annual health assessment dated April 2020 required review. In addition, one personal plan reviewed contained unclear information and required improvement. Residents health care needs were appropriately supported in the designated centre and it was evident that they were supported to access health and social care professionals as required.

There were positive behaviour supports in place to support residents manage their behaviour. The inspector reviewed a sample of behaviour management guidelines and found that they were up-to-date and guided the staff team. There were a number of restrictive practices in use in the designated centre. The provider had systems in place to identify and review the restrictive practices. However, some improvement was required in the review of restrictive practices. For example, while it was evident restrictive practices were reviewed locally, they had not been reviewed by the provider's Human Rights Committee in a timely manner. In addition, one restrictive practice observed by the inspector in use on the day of inspection required review to ensure it was the least restrictive option.

There were systems in place for safeguarding residents. The inspector reviewed a sample of incidents which demonstrated that incidents were reviewed and appropriately responded to. Residents were observed to appear comfortable and content in their home. Staff spoken with were clear on what to do in the event of a

concern or allegation.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Each resident had a personal emergency evacuation plan (PEEP) in place which guided the staff team in supporting the residents to evacuate. There was evidence of regular fire evacuation drills taking place in the centre.

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19, with contingency plans in place for staffing and isolation of residents, if required. There was infection control guidance and protocols for staff to implement while working in the centre including regular cleaning schedules and temperature checks. Personal protective equipment (PPE), including hand sanitisers and masks, were available and were observed in use in the centre on the day of the inspection. The centre had access to support from Public Health.

Regulation 17: Premises

The designated centre consisted of two purpose-build houses located close to one another. The centre was well maintained and decorated in a homely manner. However, there were areas of paint in the premises which required attention.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place for the assessment, management and ongoing review of risks in the designated centre. Risks were managed and reviewed through a centre specific risk register. The risk register outlined the controls in place to mitigate the risks.

Judgment: Compliant

Regulation 27: Protection against infection

There were systems in place for the prevention and management of risks associated with infection. There was evidence of contingency planning in place for COVID-19 in relation to staffing and the self isolation of residents. There was infection control

guidance and protocols in place in the centre.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place which were serviced as required. There was evidence of regular fire evacuation drills taking place and guidelines in place to support all persons to evacuate in the event of a fire.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Each resident had an assessment of need in place which identified residents' health and social care needs. The assessment informed the resident's personal support plans. However, one healthcare assessment and personal plan required review.

Judgment: Substantially compliant

Regulation 6: Health care

The health care needs of residents were set out in their personal plans which guided staff to support residents manage their health. Residents' were facilitated to attend appointments with health and social care professionals as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were positive behaviour supports in place which were up-to-date and suitably guided the staff team support residents.

There were a number of restrictive practices in use in the designated centre. The provider had systems in place to identify and review the restrictive practices. However, some improvement was required in the timely review of restrictive

practices to ensure they were the least restrictive.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to safeguard residents. There was evidence that incidents were appropriately managed. Staff spoken to were clear on what to do in the event of a concern. Residents were observed to appear relaxed and content in their home.

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	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Dun Aoibhinn Services - Cashel OSV-0005060

Inspection ID: MON-0028319

Date of inspection: 28/04/2021

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Not Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The staff members concerned will be booked on the required trainings in safeguarding, fire safety and de-escalation and intervention techniques. Specific training related to the residents' needs has been identified and will be scheduled. These trainings will be completed by 31/08/2021.</td></tr>
<tr><td>Regulation 17: Premises</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 17: Premises:
Quotes have been obtained for identified areas and works to be completed by 31/07/2021.</td></tr>
<tr><td>Regulation 5: Individual assessment and personal plan</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
The identified healthcare assessment and personal plan was updated 29/04/2021.</td></tr>
</table>

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Arrangements are being put in place for the review of restrictions by the Human Rights Committee in 2021. The restrictive practice identified by the Inspector was reviewed on 29/04/2021 and a less intrusive option has been put in place.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	31/08/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/07/2021
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social	Substantially Compliant	Yellow	29/04/2021

	care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	29/04/2021
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	30/09/2021