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

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| Name of designated centre: | Cairdeas Services Belmont |
| Name of provider: | Brothers of Charity Services Ireland CLG |
| Address of centre: | Waterford |
| Type of inspection: | Unannounced |
| Date of inspection: | 01 August 2023 |
| Centre ID: | OSV-0005077 |
| Fieldwork ID: | MON-0038935 |

## About the designated centre

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

Cairdeas Services Belmont consists of two single storey houses based on a campus that is located on the outskirts of a city. The centre provides full-time residential support for a maximum of 11 residents, of both genders between the ages of 40 and 80, with intellectual disabilities including those with additional needs. One house can support six residents while the other can support five residents. All residents have their own individual bedrooms and other rooms throughout the two houses that make up this centre include kitchens, living or sitting rooms, bathrooms and staff offices. Residents are supported by the person in charge, clinical nurse managers, staff nurses and care assistants.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 10 |

## How we inspect

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

As part of our inspection, where possible, we:

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

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

**1. Capacity and capability of the service:**

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

**2. Quality and safety of the service:**

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

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

**This inspection was carried out during the following times:**

| Date | Times of Inspection | Inspector | Role |
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| Tuesday 1 August 2023 | 07:50hrs to 18:00hrs | Conor Dennehy | Lead |

## What residents told us and what inspectors observed

Throughout this inspection staff members on duty interacted appropriately with residents. The atmospheres encountered in both houses was generally calm on the day of inspection. While residents' bedrooms were seen to be well-presented, some wear and tear was evident in the two houses.

This designated centre was made up of two houses located on the same campus. Combined the two houses could support a maximum of 11 residents. Both houses were visited by the inspector during the day, although the inspector did spend most of his time in one of the houses. On the day of inspection, 10 residents were living in the centre (five in each of the two houses). While some of the residents would ordinarily be attending day services, such day services were on holiday at the time of this inspection. As a result the inspector met nine of the residents during the day.

When the inspector arrived at the first house to commence the inspector, most of the five residents living there were in still in bed. During an initial walkthrough of this house it was noted that the bedroom doors of three residents had been left open as the residents were sleeping. At this time one resident was up and was being supported with their breakfast by a staff member. Not long after some staff and the person in charge arrived to commence their shifts and warmly greeted this resident. The resident responded positively to such greetings.

As the morning progressed, more residents were supported to get up, to receive personal care and to have breakfast. Some of the residents did greet the inspector but did not engage significantly with the inspector beyond this. One of the residents appeared to spend all of their day in their bedroom but it was acknowledged that this was related to the particular needs of this resident. Most of the residents in this house, remained there during the inspection but one of the residents did leave the house for a period to go on an outing using a vehicle provided.

For the residents who remained in this house during the day, it was observed that two residents spent some time doing some art in the house's living room. One of these residents had an interest in sport and it was seen that a hurling match and a rugby match were put on a television in the house's conservatory for the resident to watch. The resident spent some intermittent time watching these matches and at times appeared to be engaged in this. For the resident who spent the day in their bedroom, some music by their favourite musician was playing when the inspector visited this resident at one point. A music therapist also visited the house for part of the day and had individual sessions with residents.

The residents in this house were seen to be interacted with and supported by staff members on duty in an appropriate, pleasant and respectful manner throughout the inspection. At one point a resident was very keen to use a communal bathroom but at the time this bathroom was being used by another resident. Staff were overheard to explain this to the resident and offered the resident an alternative bathroom to

use. Despite this the resident remained insistent on the using the occupied bathroom. Staff remained present with the resident until this bathroom was available for use and were very pleasant and patient in supporting the resident during this time.

Such interactions contributed to the atmosphere in this house being generally calm and relaxed while the inspector was present. It was observed that residents had their own individual bedrooms that were nicely presented and personalised to residents. For example, the resident with the interest in sport had a framed autographed GAA jersey on their bedroom wall while another resident had an award which they had previously received on display in their bedroom. Parts of some of the communal areas, such as the living room and a day room used for relaxation, were also seen to be well-furnished.

Despite this the house was show signs of wear and tear in places with some worn and chipped surfaces evident in areas. Toilets seats in some bathrooms were seen to need replacing while the inspector observed noticeable gaps between the floor and skirting boards in the conservatory area. Aside from this some areas were seen which needed further cleaning which will be discussed further elsewhere in this report. The inspector also observed that this house was tight on storage space in some areas with a resident's wheelchair seen to be stored in their en suite bathroom while some photo frames, a bin and a laundry basket were seen stored in a shower area.

Some wear and tear was evident in the other house when visited by the inspector. Again this included some worn or chipped surfaces and a toilet seat that needed to be replaced. A floor in a store room in this house was also seen to need further cleaning. Parts of this house were seen to be reasonably presented including a recently decorated multi-sensory room and some resident bedrooms seen by the inspector. It was noted though that a room which was marked as being a small lounge on the floor plans provided for this centre, did have the appearance of a vacant bedroom that was being used for storage purposes.

This house appeared to be comprised of an original building that had had an extension built on to increase the space provided. Staff members spoken with in his house indicated that the space provided allowed residents to have their own areas within the house. This was something which seen while the inspector was present with one resident spending some time in a conservatory area doing some art while another resident spent time in their bedroom which had an adjoining dining-living room. Two other residents were seen in the house's larger dining-living together in the presence of staff members.

Four of the five residents living in this house were met by the inspector during his visit there. The fifth resident was on an outing at the time of the inspector's visit and so was not met. One of these residents did briefly greet the inspector while on two occasions another resident came to the staff office while the inspector was present seeking assistance. On both occasions this resident appeared to think the inspector was a member of staff with a staff member in the vicinity providing support to the resident thereafter. A third resident raised their hand towards the

inspector as he walked by on one occasion. Staff told the inspector that this was the resident communicating that they did not want the inspector around them.

Aside from this, the residents met in this house did not engage with the inspector. While he was present the inspector observed that one of the residents was taken on a brief outing to get a soft drink while another resident appeared to be looking forward to go and meet a family member. Staff members present were overheard and observed to support residents in a respectful manner and this contributed to the atmosphere being generally calm while the inspector was present. However, on occasion the inspector did hear some vocalisations from one resident and there was identified incompatibility amongst residents in this house as will be discussed further elsewhere in this report.

While the inspector did not get much direct feedback from residents on what it was like to live in both houses of this centre, some resident and family feedback was contained within a report of a provider unannounced visit to the centre conducted in May 2023. This report indicated that four residents spoken with by representatives of the provider had said that they happy living in the centre. In terms of family feedback, it was indicated that all families were asked to complete a survey on the services provided in January 2023 with all families responding that they were happy with the care provided to their relatives.

In summary, resident and family feedback from a May 2023 provider unannounced visit report was positive. Residents were supported by staff members on duty in a pleasant and respectful manner in both houses. The bedrooms provided for residents were seen to be nicely presented and personalised but in both houses, aspects of the premises were seen that needed improvement.

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

## Capacity and capability

Some evidence of improved oversight of this centre was found during this inspection. Despite this a number of regulatory actions were found during this inspection including in similar regulations where actions had been previously identified.

This designated centre was registered until October 2024 with no restrictive condition. The purpose of the current inspection to assess progress with actions identified during the previous inspection of this centre in November 2022. During that inspection, inspectors observed poor practice in relation to governance and management, fire safety, risk management and infection prevention and control (IPC). A particular area of concern was that there was a poor level of oversight and

monitoring of the centre, which resulted in areas for improvement not being identified through the provider's auditing and review systems. This included annual reviews and provider six monthly unannounced visits, key regulatory requirements, providing little documentary evidence of the review of the care and support provided to residents.

On the current inspection it was found that two six monthly unannounced visits had been conducted since November 2022 by representatives of the provider. One of these had been completed in December 2022 with some sections of this report noted to be limited in the amount of detail provided. However, the most recent unannounced visit to the centre had been conducted in May 2023 and was done by two representatives of the provider over the course of two days. The inspector reviewed a copy of the report of this visit and noted to it to be very comprehensive in both its level of detail and focus on aspects of the care and support provided to residents. An action plan was also in place to assign responsibilities and time frames for addressing areas for improvement identified.

From reviewing this action plan it was apparent that a number of actions had been identified during the May 2023 unannounced visit with a number of these covering areas such as IPC, the premises, risk management and fire safety. It was particularly notable that the May 2023 unannounced visit highlighted a need for improvement around aspects of the auditing of the centre. The person in charge informed the inspector that the actions from the May 2023 unannounced visit were still in the process of being worked on but there was some indications that some of the identified actions were being progressed. For example, safety audits conducted for each house of the centre in June 2023 appeared to identify more relevant issues whereas similar audits conducted earlier in 2023 had not identified any areas for improvement.

The nature of the May 2023 provider unannounced visit suggested that there was an improved level of oversight from the provider for the centre but the current inspection found that regulatory actions remained in a number of the same regulations that had been highlighted during the November 2022 inspection. Following the November 2022 inspection, the provider had submitted a compliance plan response outlining the actions it would take to come back into compliance with the regulations. In doing so it was indicated by the provider that it would be in compliance with such regulations by 28 February 2023. There was evidence on the current inspection that some specific actions outlined in the compliance plan response had been completed which did bring about improvements. However, both the findings of the provider's May 2023 unannounced visit and the current inspection indicated that further improvement was needed to ensure compliance with the regulations.

One specific area highlighted under Regulation 23 Governance and management during the November 2022 inspection related a July 2020 assessment which identified a compatibility issue in one house. An action from the July 2020 assessment was that one resident should live in a separate apartment area with no progress on this having being made at the time of the November 2022 inspection. During the current inspection it was indicated that the resident's living circumstances

remained unchanged. However, it was highlighted that risk assessments completed in June 2023 for this house had rated the risk of residents living together as being a lower risk. In addition, staff spoken with during this inspection outlined how such compatibility concerns were managed through supervision of residents by staff, a specific routine followed by one resident and the house where residents lived affording them space to be in their own areas.

Despite this, another compatibility had been completed for the relevant house the week before the current inspection. While it was indicated that this assessment had yet to be discussed with the provider's multidisciplinary team and it was acknowledged that it did highlight some compatibility amongst residents, the outcome of assessment suggested ongoing incompatibility amongst some residents. For example, one resident was described as being "somewhat incompatible" with the other four residents they lived with while another resident was indicated as being "very incompatible" with a peer. While it was seen that the supports provided to residents sought to minimise the impact of any incompatibility, it was also notable that compatibility of residents had been raised as issue in previous inspections of this centre going back to June 2018. The continued incompatibility of some residents could detract from the provision of a homely living environment which the centre's statement of purpose indicated as being an objective for the centre.

The same statement of purpose indicated that another objective was to provide a safe living environment and no safeguarding notifications had been notified to the Chief Inspector of Social Services since the November 2022 inspection. However, incident reports reviewed did indicated that there had some occasions when residents had impacted peers in the house with identified resident incompatibility. For one example, on one occasion a resident was described as appearing "to be afraid" of peer, while in another incident a resident appeared upset and reported that a peer had pulled their hair. While such incidents were reviewed internally by the provider, they were not screened and reported as safeguarding concerns in a manner consistent with the provider's national safeguarding policy. This approach appeared to have been influenced by a regional provider procedure that set out how peer-to-peer incidents were to be responded to.

This regional procedure did not appear consistent with the provider's national safeguarding policy which provided for an explicit zero tolerance approach to abuse. As such incidents were not regarded as safeguarding concerns, they had not been notified to the Chief Inspector. In keeping with regulatory requirements, any alleged or suspected safeguarding matter must be notified to the Chief Inspector within three working days. Aside from this, regulations also require specific events to be notified to the Chief Inspector on a quarterly basis but during this inspection it noted that some of these events had not been submitted as required. The person in charge submitted a retrospective notification for one of these events in the days following this inspection. During the course of the inspection, management of the centre were also reminded of the requirement to submit some specific follow-up information to the Chief Inspector regarding two notifications that had been submitted for the centre during 2022. Again, in the days following this inspection the person in charge submitted the required follow-up information.

## Regulation 14: Persons in charge

The person in charge at the time of the November 2022 inspection had commenced a period of notified absence in May 2023 until December 2023. In their absence another person in charge had been appointed to oversee the running of the centre. This person was responsible for this designated centre only was suitably experienced and qualified to meet the requirements of the regulations. During this inspection they ensured that all information requested by the inspector was made available while staff members spoken with talked positively of the support provided by this person in charge.

Judgment: Compliant

## Regulation 15: Staffing

While there were staffing challenges affecting the health and social care sector generally, staffing in this centre was generally provided in accordance with the centre's statement of purpose. However, it was highlighted that in one house there was some nursing vacancies which meant that on occasion, some nursing shifts would be covered by care assistants. It was indicated thought that on such occasions, nursing support would be available from the other house of the centre while recruitment efforts were being made to fill these vacancies. Some agency staff were working in the centre and staff members spoken highlighted the importance of maintaining a consistency of staff support particularly in one house. It was indicated though that, in the weeks leading up to this inspection, the consistency of staff support had improved.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

Records provided indicated that staff had completed training in areas such as fire safety, safeguarding, de-escalation and intervention, IPC and first aid. However, some staff were overdue refresher training in some of these areas.

Judgment: Substantially compliant

## Regulation 23: Governance and management

There was an improved level of oversight from the provider than compared to the November 2022 inspection. However, based on the findings of this inspection the provider had not achieved compliance in certain regulations by 28 February 2023 as initially indicated and a number of regulatory actions were found during this inspection in such regulations. This indicated that further improvement was needed to ensure compliance with the regulations. There was identified incompatibility amongst residents in one house with concerns around residents' compatibility having been raised by inspections going back to June 2018. The continued incompatibility of some residents could detract from the provision of a homely living environment which the centre's statement of purpose indicated as being an objective for the centre. An annual review for 2022 had been recently conducted and while this did include feedback from residents and their families, the annual review did not explicitly assess the centre against relevant national standards as required.

Judgment: Not compliant

## Regulation 31: Notification of incidents

Some incidents which required notification to the Chief Inspector of Social Services had not been notified at the time of inspection. These included safeguarding matters, an activation of the fire alarm and the expected passing away of a resident.

Judgment: Not compliant

## Quality and safety

While there had been some improvement since the November 2022 inspections, there remained regulatory actions particularly regarding IPC and fire safety.

In designated centres it is required that there be adequate arrangements for containing fires. This is important in order to provide a protected evacuation route and to prevent the spread of fire and smoke. During the November 2022 inspection concerns were identified around aspects of fire containment in the centre. These included some fire doors (which are specifically intended to prevent the spread of fire and smoke) being wedged open and a wooden panel between a kitchen and an evacuation corridor not being fire resistant. On the current inspection it was indicated that this panel had been replaced with a substance that provided 30 minute fire resistance. In addition, at no point during the inspection were any fire doors observed to be wedged open. Despite this though, the inspector did see that some further improvement was needed around fire containment. For example, one

of the houses had a gap in the wall between its kitchen and dining area.

This gap was ordinarily covered by a hatch that had been in place for years. During the May 2023 provider unannounced visit for the centre it had been identified that fire containing closers were not present on the hatch. This was in the process of being addressed but at the time of this inspection, the hatch had been removed meaning that in event of a fire smoke could pass from the kitchen into the dining area and vice versa. As this hatch was not seen on the day of inspection it was unclear if the hatch itself was sufficiently fire resistant. Some holes were also seen in one fire door in each of the two houses visited which could impact the intended use of these fire doors. In one of these houses the inspector observed a noticeable visual difference in the appearance of some fire doors present. As such the inspector sought further documentary assurances from the provider that the doors in both houses offered a sufficient level of fire containment. In response, it was indicated following the inspection that the provider would be getting a suitably qualified competent person to review the fire doors in both houses during September 2023.

Aside from fire containment matters, the houses were equipped with fire safety systems that included fire alarms, emergency lighting, fire extinguishers, fire hoses and fire blankets. Such systems were being serviced by external contractors to ensure that they were in proper working order. Multiple fire exits were present in each house with these seen to be unobstructed on the day of inspection. It was seen though that break glass units near two exits in one house were missing their glass. Fire evacuation procedures were on display in both houses. As part of the overall evacuation plan for one house it was seen that a specific evacuation order was in place for the residents of the house based on their needs. Despite this one staff member indicated that a different resident would be evacuated last than the resident that was listed on this evacuation plan. Another staff member spoken with in this house was aware of the correct evacuation order.

Fire drills had been conducted in both houses with records of these indicating that such drills were done to reflect times when staffing levels would be at its lowest. When reviewing these fire drill records for one house it was noted that low evacuations times were recorded although limited detail as to how the drill went were included. The drill records in the other house contained more details and indicated that a specific evacuation plan was followed which involved staff support coming from other houses on the campus. Evacuation times in his house were higher compared to the other house of the centre and in one drill an evacuation time was recorded even though one resident was described as refusing to evacuate. This resident had subsequently evacuated without issue on a drill done since then and staff spoken with expressed the view that in the event of a real fire the resident would evacuate. Despite this the resident's personal emergency evacuation plan (PEEP) did not outline any guidance on how to support the resident to evacuate in the event that they did refuse.

Details around fire evacuation were contained within an overall emergency plan for each house. Such plans are an important aspect of risk management in a designated centre and the provider also had a risk management policy in place. In keeping with this various risk assessments were being maintained related to areas such as IPC

and fire safety. The November 2022 inspection had found that there a number of inherent risks in such areas that were not being appropriately recognised or managed appropriately. Based on the findings of this inspection, such areas continued to need some improvement and will be reflected under the findings for Regulation 27 Protection against infection and Regulation 28 Fire precautions respectively. However, it was noted that while some of the risk assessments had been recently updated, some of the control measures outlined for COVID-19 related risks were outdated. For example, such assessments indicated that visiting was restricted but the person in charge stressed that this had not been the case for some time.

Some signage related to COVID-19 and IPC were on display in both houses. Under the regulations measures should be adopted in a designated centre that promote effective IPC practices. During the November 2022 inspection this was found not to be the case. It was seen that measures had been taken by the provider in response to the highlighted issues during that inspection. For example, sluicing equipment had been removed from the houses' utility rooms while mops were now being stored inside the houses rather than outside exposed to the elements. In the compliance plan response to the November 2022 inspection the provider had also indicated that local IPC audits would be carried out with greater attention to detail to ensure areas that require improvement were addressed. Despite this, on the current inspection the inspector was informed that no specific IPC audits were currently being done. While it was indicated that this was being reviewed internally, this inspection found that IPC practices continued to need improvement.

A key aspect of effective IPC is ensuring that there are adequate cleaning practices but in one house of the centre, the inspector observed some areas that needed further cleaning. For example, a room where some food was stored was seen to be unclean while vents in some rooms were visibly unclean. The person in charge indicated that they had recently introduced a deep cleaning schedule for the house with certain staff assigned to clean specific rooms on a monthly basis. Aside from this there was a pre-existing daily cleaning schedule in place for the house, and while staff spoken with indicated that cleaning was being done regularly, the inspector observed a number of gaps in the house's daily cleaning records for June and July 2023. Taking into account his observations and the cleaning record gaps seen, the provider was not assured that there was effective and consistent cleaning being carried out in this house.

It was acknowledged that the age of this house did make effective cleaning in some areas more difficult. The person in charge also highlighted how they had requested some external cleaners for the centre which were not in place. Aside from cleaning matters, some other IPC measures were reviewed. As part of these it was seen that the some personal protective equipment (PPE), such as face masks, was kept in the centre's houses. It was indicated that other PPE like gowns had been moved out of the houses since the last inspection to a building on campus and that these were accessible as needed. Hand sanitiser was also present in both houses but in one house the inspector identified a bottle of hand sanitiser that had expired in April 2023 while the other house two bottles of hand sanitiser were found that had expired in March 2021. These were highlighted to the person in charge who

removed them. The inspector also reviewed an IPC folder in one house and, while this did include some updated guidance in this area, it was noted that some of the folder's contents were outdated.

## Regulation 17: Premises

Some wear and tear was evident in both houses of the centre. This included some toilet seats needing replacing and some chipped and worn surfaces. The inspector also observed that one house was tight on storage space in some areas with a resident's wheelchair seen to be stored in their en suite bathroom while some photo frames, a bin and a laundry basket were seen stored in a shower area. In the other house a room which was marked as being a small lounge on the centre's floor plans provided appeared to be being used for storage purposes.

Judgment: Substantially compliant

## Regulation 26: Risk management procedures

While some risk assessments had been recently updated, some of the control measures outlined for COVID-19 related risks were outdated. For example, such assessments indicated that visiting was restricted.

Judgment: Substantially compliant

## Regulation 27: Protection against infection

Taking into account the inspector's observations and the cleaning record gaps seen, effective and consistent cleaning was not being carried out in one house. No IPC audits were being conducted at the time of inspection. Expired bottles of hand gel were seen in both houses of the centre. An IPC folder in one house contained outdated guidance.

Judgment: Not compliant

## Regulation 28: Fire precautions

In one of the houses there was a gap in the wall between its kitchen and dining area meaning that in event of a fire smoke could pass from the kitchen into the

dining area and vice versa. This gap which was ordinarily covered by a hatch that had been in place for years. It had been identified in May 2023 that fire containing closers were not present on the hatch and this was in the process of being addressed. As this hatch was not seen on the day of inspection it was unclear if the hatch itself was sufficiently fire resistant. Holes in two fire doors were seen during this inspection which could impact their effectiveness. Given noticeable visual differences in the appearance of some fire doors, further assurances were needed that the fire doors in this centre offered a sufficient level of fire containment. One staff member outlined a different evacuation order for one house than the order that was was listed on the house's evacuation plan. A resident's PEEP did not provide guidance on how to support the resident in the event that they refused to evacuate the house where they lived.

Judgment: Not compliant

## Regulation 6: Health care

Residents' wishes in terms of end-of-life care were found to be clearly documented, to ensure their rights and choice at end of life were respected. This had been improved upon since the November 2022 inspection.

Judgment: Compliant

## Regulation 8: Protection

There was an identified incompatibility amongst residents in one house and the supports provided to residents sought to minimise the impact of this. However, there had been some occasions in this house when residents had impacted peers. While such incidents had been reviewed, given their nature they not been reported and screened in line with the provider's national safeguarding policy. Given this policy's explicit zero tolerance approach to abuse, any potential safeguarding matters needed to be reported and managed consistently.

Judgment: Substantially compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Regulation 14: Persons in charge | Compliant |
| Regulation 15: Staffing | Substantially compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 31: Notification of incidents | Not compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Substantially compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 27: Protection against infection | Not compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 6: Health care | Compliant |
| Regulation 8: Protection | Substantially compliant |

# Compliance Plan for Cairdeas Services Belmont OSV-0005077

## Inspection ID: MON-0038935

## Date of inspection: 01/08/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 15: Staffing | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>• Where there is a reliance on the use of agency/ locum relief staff members. every effort will be made to use consistent, familiar agency/ locum relief staff to ensure continuity of service delivery for residents<br><br>• Despite the challenges faced nationally across the health and social care sector, particularly in relation to recruiting nurses the Provider is committed to continued efforts to recruit staff for this centre. | |
| Regulation 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>• The service manager and PIC will liaise with the training department to schedule outstanding refresher mandatory training for staff who require same. The PIC will oversee and monitor the completion of refresher training for all staff. | |
| Regulation 23: Governance and management | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>• We will ensure that the Annual report meets the requirements as laid out in the regulations.<br><br>• The provider will ensure that the centre is safe, consistent, effectively monitored and compliant with regulations on an ongoing basis. This will be addressed by ensuring the unannounced 6 monthly provider audits are more robust, focusing on those aspects of the service identified as requiring improvement. The content of such audits will inform the development of a clear action plan to ensure all actions have been addressed within the set timeframe. | |

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| • The Compatibility Assessment reviewed at this inspection was a pilot assessment using a new, recently developed compatibility assessment tool. This pilot assessment was completed at the request of management and monitoring team in relation to the possible removal/reduction of the safeguarding plans in place for two individuals, not all residents. The assessment is not complete and requires further review by the MDT and Local Management Team Any required actions arising from this finalized review will be considered and planned in order to mitigate potential risks that may arise as a result of the compatibility profile of residents within the centre. |

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| Regulation 31: Notification of incidents | Not Compliant |

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• All concerns/allegations of abuse will be addressed through the organisations safeguarding policy and the required notifications will be submitted via the HIQA Portal within required timeframes.
• Increased attention will be given to the submission of quarterly notifications to ensure that they are an accurate reflection of all events which have occurred within the quarter. These will be completed by the PIC overseen by the Services Manager
• All quarterly notifications will be submitted within regulatory timeframes.

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| Regulation 17: Premises | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
• Maintenance issues identified are scheduled to be addressed with some repairs currently underway

• The use of space in both houses will be reviewed to identify additional storage capacity and to ensure that items are stored appropriately

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| Regulation 26: Risk management procedures | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• All Covid -19 related risk assessments will be reviewed and updated in line with current public health guidance.

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| Regulation 27: Protection against infection | Not Compliant |

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• The provider will ensure that the centre is safe, consistent, effectively monitored and compliant with National Standards for infection prevention and control.
• Team meetings have been held to reinforce the importance of IPC, appropriate storage of equipment and signing of cleaning records.

• IPC specific audits have been implemented to locally identify and action areas for improvement. The content of such audits will inform the development of a clear action plan to address any areas requiring improvement. The PIC will ensure all actions arising are on schedule for completion within the set timeframe. This will be overseen by the Service Manager

• An audit was completed of all PPE including hand gels for expiry dates this has been added to the IPC audit to be completed monthly to monitor stock on an ongoing basis.

• Risk assessments have been reviewed and updated to reflect up-to-date information and guidance in the IPC folder.

• Staff will be reminded to ensure that all items on the cleaning schedule are completed as required. The cleaning of vents has been added to the cleaning schedule.

• Once all maintenance works are completed a contract cleaning company will complete an initial deep clean of both residences. A monthly deep cleaning schedule has been developed to supplement the daily cleaning schedule to ensure that the overall cleaning of the center is more robust.

• The freezer has been repaired to allow for deep cleaning and the flooring in that particular room has been replaced, making the area conducive to effective cleaning.

| Regulation 28: Fire precautions | Not Compliant |
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The provider will ensure that the centre is safe, consistent and effectively monitored in compliance with National Standards for fire precautions. These measures are being implemented by staff.The PIC will ensure all actions arising are on schedule for completion within the advised time frame and will ensure all staff members are aware and knowledgeable of their roles and responsibilities in relation to fire regulations.

• A fire competent person commenced a detailed assessment of all fire doors within the center on 04/09/2023 to ensure that fire safety compliance is being achieved. Any actions arising from this report will be actioned by the provider.

• The issues identified during the inspection in relation to two fire doors have been addressed.

• The wooden panel above and below the hatch has been made fireproof. Fire-resistant glass has now been fitted.

• Staff members have been reminded of the importance of knowing the sequence of evacuation. This will be discussed regularly at team meetings.

• The evacuation needs of residents have been reviewed since the August inspection. The PEEP of one resident has been updated to reflect and provide clear direction of how staff should support them if they refuse to evacuate the premises.

• Glass has been ordered for 2 breakglass units

• Staff have been reminded to provide sufficient details when completing fire drill reports. Drill reports will be reviewed by the PIC following completion to ensure that they provide comprehensive detail.

| Regulation 8: Protection | Substantially Compliant |
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Outline how you are going to come into compliance with Regulation 8: Protection:
• All concerns/allegations of abuse will be addressed through the organisations safeguarding policy and the required notifications will be submitted via the HIQA Portal within required timeframes
Safeguarding will continue to be a standing agenda at team meetings

## 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 |
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| Regulation 15(2) | The registered provider shall ensure that where nursing care is required, subject to the statement of purpose and the assessed needs of residents, it is provided. | Substantially Compliant | Yellow | 31/12/2023 |
| 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 | 31/12/2023 |
| Regulation 17(1)(b) | The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and | Substantially Compliant | Yellow | 31/10/2023 |

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| | internally. | | | |
| Regulation 17(7) | The registered provider shall make provision for the matters set out in Schedule 6. | Substantially Compliant | Yellow | 30/08/2023 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | Not Compliant | Orange | 01/10/2023 |
| 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. | Substantially Compliant | Yellow | 31/03/2024 |
| 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 responding to emergencies. | Substantially Compliant | Yellow | 30/09/2023 |
| Regulation 27 | The registered provider shall ensure that | Not Compliant | Orange | 30/09/2023 |

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| | 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. | | | |
| Regulation 28(1) | The registered provider shall ensure that effective fire safety management systems are in place. | Substantially Compliant | Yellow | 31/10/2023 |
| Regulation 28(3)(a) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Not Compliant | Orange | 31/10/2023 |
| Regulation 28(3)(d) | The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations. | Substantially Compliant | Yellow | 10/08/2023 |
| Regulation 31(1)(f) | The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse | Not Compliant | Orange | 02/08/2023 |

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| | incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident. | | | |
| Regulation 31(3)(b) | The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which the fire alarm equipment was operated other than for the purpose of fire practice, drill or test of equipment. | Not Compliant | Orange | 19/09/2023 |
| Regulation 31(3)(e) | The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any deaths, including cause of death, not required to be notified under paragraph (1)(a). | Not Compliant | Orange | 04/08/2023 |

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| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Substantially Compliant | Yellow | 01/08/2023 |