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

Issued by the Chief Inspector

Name of designated centre:	Boherduff Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Tipperary
Type of inspection:	Short Notice Announced
Date of inspection:	10 June 2021
Centre ID:	OSV-0005291
Fieldwork ID:	MON-0033136

About the designated centre

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

Boherduff Services provides a full-time residential and shared care service for children and adults. The centre is based in Co. Tipperary. The capacity of the centre is four people of mixed gender who have been diagnosed with an intellectual disability, including those with a diagnosis of autism spectrum disorder and challenging behaviour. At the time of this inspection there were two residents living there, a third resident in receipt of shared care and one vacancy. The residents were all over 18 years. The centre is a single-storey detached building with five bedrooms, a kitchen and living room. A section of the house is allocated for the sole use of one resident. There are large gardens around the premises and outdoor play equipment at the rear. The staffing complement is described in the statement of purpose as matching the particular needs of the people supported. The staffing team in place consists of a team leader (the person in charge), social care workers and care assistants. The statement of purpose sets out that the centre aims to provide a warm and homely environment that is tailored to individual preferences and needs. The centre has the use of three vehicles for the transportation of residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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
Thursday 10 June 2021	10:15 am to 5:30 pm	Deirdre Duggan	Lead

What residents told us and what inspectors observed

From what the inspector observed, overall residents enjoyed a good quality of life in this centre and were offered a person centred service, tailored to their individual needs and preferences. The inspector saw that there was evidence of consultation with residents and family members about the things that were important to them. However, the management systems in place in the centre were not ensuring that a safe and effective service was being provided at all times and this inspection found that while some progress had been made, some non compliance's found in previous inspections had still not been adequately addressed at the time of this inspection. This inspection found that there was non compliance with the regulations in a number of areas including governance and management, staffing, fire safety and personal plans.

The centre comprised a large bungalow that could accommodate three residents and an interconnected apartments that could accommodate one resident. The centre was on it's own grounds in a countryside location just outside a large town. There were three residents living in the centre. Two residents availed of a full time residential service and one resident availed of a part time service and also used the centre on occasion as a base for day service activities during the COVID-19 pandemic. Both male and female residents lived in this centre. This centre was registered to provide a service to both adults and children. At the time of this inspection all of the residents were over 18 years of age. All of the residents living there had transitioned into adulthood while living in the centre.

Residents' bedrooms were personalised and the centre was seen to be homely and inviting. Residents living in the main house had access to a sensory room that staff had decorated and this was seen to contain comfortable seating and equipment such as sensory lighting and a foot spa. One resident used a wheelchair some of the time. The front door had recently been replaced and a ramp put in place to ensure that all areas of the centre were accessible to all of the residents living there. Residents had access to a large, pleasant garden area that contained equipment such as a swing and a trampoline. Some improvements were required in some areas however. Some flooring, such as in the sensory room and the main bathroom, was seen to require repair or replacement and there was an area of staining on the kitchen ceiling following a leak that required painting, as well as some painting required following the replacement of the front door. Externally, the premises was noted to require painting also, although the person in charge reported that this had been completed since the previous inspection in late 2019.

The apartment attached to the centre was laid out in a manner that suited the needs of the resident that lived there and had been adapted to provide a safe and secure environment in line with their assessed needs. Although minimalistic in nature, significant efforts had been made to personalise this space for the resident that lived there, and the inspector saw that staff were innovative and creative in their efforts to make this space as inviting as possible for the resident. There were

murals in the hall and bedroom that would be of interest to the resident, and the resident had the use of a projector that provided a safe means for them to access preferred television and multimedia. The apartment had it's own entrance and exit points and was connected to the main house by a door that was used primarily by staff. For example, at night, a waking night staff and sleepover staff based in the main house would provide supervision and support to the resident in the apartment also.

On the day of the inspection, the residents of this centre were attending day services for most of the day. However, the inspector met briefly with two of the three residents and the staff members that supported them. This inspection took place during the COVID-19 pandemic. Communication between the inspector, residents, staff and management took place in adherence with public health guidance. Residents communicated in a variety of ways. Although the residents living in this centre were unable to tell the inspector in detail their views on the quality and safety of the service, the inspector saw that residents appeared contented and relaxed in the centre and were comfortable in the presence of the staff supporting them. Both residents indicated that they did not wish to stay long in the company of the inspector and this wish was advocated for them by staff present and respected by the inspector. Due to restrictions in place during the COVID-19 pandemic it was not possible for the inspector to meet with family members on the day of this inspection. An annual review had been completed and this showed that residents and their families had been consulted with and their views obtained on the service that residents were receiving.

The person in charge and staff working in the centre spoke about how family communication was maintained and facilitated in the centre. Staff in the centre spoke about how residents' family members were involved in residents lives. Due to the COVID-19 government restrictions and the specific support needs of the residents living in this centre, visits from family members were usually planned in advance and visiting in the centre was not taking place as often as prior to the pandemic. However, regular phone and video contact was maintained and residents were supported to meet with family members and celebrate important occasions with them. One resident had recently celebrated a milestone birthday and had been facilitated to enjoy this in a manner that suited their needs.

Staff were respectful in their interactions with residents. Residents appeared comfortable to move about their own home freely and with the assistance of staff. The inspector observed a home cooked meal being prepared for residents and staff told the inspector this was a favoured meal of one of the residents.

The inspector saw that the residents were supported to make choices about how they would spend their day and were facilitated to access the community in line with government guidelines during the COVID-19 pandemic.

Residents had access to transport to facilitate community access and to attend day services and medical appointments. Where restrictions associated with COVID-19 presented challenges to residents carrying out their usual activities, alternatives were put in place, such as access to local walking areas and takeaway meals and

drinks.

There were significant restrictions in place in the centre including the locking of some doors on occasion, observation windows that allowed staff to observe a resident from a different room unobserved during periods of anxiety, and the use of harnesses on the bus for some residents. Some of these were associated in particular with one resident. Most of these restrictions had been reviewed by a human rights committee and were seen to be in place in line with best practice. However, one physical intervention that had been identified as requiring review on previous inspections remained in place and there was no evidence to suggest that this had been reviewed or approved by the human rights committee as was the practice within this organisation. Although there was a risk assessment in place for this intervention, it was not informed by review from an appropriate professional and therefore did not provide assurances as to the safety of this practice. There was also no evidence to show that this physical intervention was safe, the most appropriate, or the least restrictive practice that could be used. This will be discussed further in the section of this report that deals with quality and safety.

Overall, this inspection found that there was a significant level of non compliance with the regulations and that this meant that residents were not always being afforded safe services that met their assessed needs. 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

There was a clear management structure present and overall this centre was found to be providing a responsive and good quality service to the residents living there. However, management systems in place did not ensure that the service provided was safe, consistent, and appropriate to residents' needs at all times. Previous inspections of this centre in 2018 and 2019 had identified non compliance that was related to a specific issue, a physical intervention for one resident that had been taking place since 2016. The provider had submitted numerous compliance plans outlining the actions they had, and were, taking to bring the centre into compliance. However, this inspection found that these actions had still not satisfactorily addressed this non compliance at the time of this inspection.

The person in charge reported to a services manager participating in the running of the centre, who in turn reported to a regional services manager. Reporting structures were clear and there were organisational supports such as audit systems in place that supported the person in charge and the staff working in the centre, and provided oversight at a provider level. However, these audits did not identify or recognise the impact of the continued non compliance that was occurring. Staff

were receiving regular formal supervision and there was evidence of regular contact between the staff team, the person in charge and the services manager.

The person in charge was present on the day of the inspection and had remit over this centre only at the time of the inspection. This person had recently returned to the role following an extended period of leave. The services manager was also present in the centre on the morning of the inspection. Both of these individuals were very knowledgeable about the residents and their specific support needs and this enabled them for the most part to direct a high quality service for the residents living in the centre. The inspector saw that both individuals maintained a presence in the centre and had an active role in maintaining oversight and the running of the centre, and staff spoken to reported a supportive environment fostered by the person in charge. The person in charge told the inspector that they were highlighting concerns relating to staffing and the provision of appropriate behaviour support input for a resident in the centre on an ongoing basis. The management team present acknowledged that the service was not yet fully meeting the assessed needs of one resident, despite significant and repeated efforts to do so.

As mentioned in the previous section of this report, a resident was subject to a significant physical intervention on occasion in this centre due to behaviours of concern, including self injurious behaviours. This had been identified as requiring review on previous inspections, and while significant work had taken place to reduce the frequency of use of this intervention, it was seen to be still in use, having occurred five times in the period January-June of this year. Senior management were openly allowing this practice to continue in the absence of a more suitable alternative, but most had not ever observed the practice taking place. This inspection found that despite the work undertaken to reduce the frequency of this intervention, management practices in the centre had not been sufficiently robust to ensure that this practice was either eliminated and replaced with a suitable alternative, or was appropriately reviewed to ensure that it was safe, appropriate, and approved for use in line with best practice. Management in the centre cited the COVID-19 pandemic and the lack of a local behaviour support team as key reasons as to the continuation of the non compliance with the regulations in this centre. At the time of this inspection there was no clear plan in place to rectify the non compliance.

Staffing levels in the centre had improved since the previous inspection. However, the inspector was told that a deficit remained at certain times and this was having an impact on residents in the centre. When the two full time residents were present, there were four staff restored for duty in the centre by day. When the third resident was present, there were five staff present by day. When the third resident was present in the centre, staffing levels by day were not adequate to provide a person centred service to all residents at all times, due to a requirement for three staff to be present with one resident and another resident requiring two staff to access the community. This meant that sometimes a resident was unable to take part in community based activities or to leave the centre for prolonged periods due to the need for their assigned staff to be present in the centre to assist with the support needs of another resident. The services manager told the inspector that the additional staffing needs had been identified and that funding for an additional staff

member was in the process of being applied for but was not yet sanctioned. The person in charge confirmed that in the interim, at times that additional staffing was known to be required, such as if a resident were unwell or wanted to take part in a planned activity, then this was provided.

By night, a waking night staff and a sleepover staff were present to attend to residents. While this was seen to be sufficient to meet the needs of residents in ordinary circumstances, the inspector was not fully assured that appropriate consideration had been given to assessing if two staff could safely evacuate all three residents in the event of an emergency in the centre, such as an outbreak of fire.

The next section of the report will reflect how the management systems in place were contributing to the quality and safety of the service being provided in this designated centre.

Regulation 15: Staffing

This centre was staffed by a core group of dedicated staff with a skill mix appropriate to the assessed needs of the residents living there. Staffing levels in the centre had increased since the previous inspection.However, the registered provider had not ensured that there was a sufficient number of staff on duty in the centre to meet the residents' assessed needs at all times. A funding application had been submitted and in the interim, additional staffing was provided at times of anticipated need. No agency staff had been employed in this centre in the previous year.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had received training in areas such as fire safety and safeguarding and protection of vulnerable adults as well a variety of other disciplines. Training records viewed indicated that two new staff had not yet taken part in fire safety training. This was scheduled to take place within the fortnight following the inspection. Some staff training records in respect of safeguarding was not available on the day of the inspection. The person in charge assured the inspector that this training had been completed and committed to updating the records in the days following the inspection. Additional training had taken place during the COVID-19 pandemic in areas such as hand hygiene and the donning and doffing of personal protective equipment (PPE). Formal supervision was occurring in the centre and guidance issued by public health was available to staff.

Judgment: Substantially compliant

Regulation 23: Governance and management

Non compliance identified in previous inspections had not been satisfactorily addressed. Management systems in place in the designated did not at all times ensure that the service provided is safe, appropriate to residents' needs and effectively monitored. An annual review had been carried out in respect of this centre and a six monthly audit completed. These did not identify that a physical intervention taking place in the centre was continuing to occur without adequate review to ensure that it was safe, appropriate, and approved for use in line with best practice. The registered provider had not ensured that the designated centre was adequately resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. Staffing levels in the centre were not always adequate to meet the assessed needs of residents and the provision of adequate behaviour support input was impacted by lack of resources available to the centre. A recommendation made by a behaviour support professional had not been trialled due to the resources not being present in the centre.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had notified the chief inspector in writing, as appropriate, of any incidents that had occurred in the designated centre.

Judgment: Compliant

Regulation 32: Notification of periods when the person in charge is absent

The office of the chief inspector had been given notice in writing that the person ordinarily in charge of this designated centre was absent for more than 28 days as required by the regulations.

Judgment: Compliant

Quality and safety

The wellbeing and welfare of residents was for the most part maintained by a good standard of evidence-based care and support. This meant that most of the time safe and good quality supports were provided to the three residents in this centre. However, as mentioned already in this report, a practice in place that had been highlighted in previous inspection reports was ongoing and this meant that safe, evidence-based care and support was not being provided to one resident at all times.This inspection also found that there were some improvements required in the areas of fire safety, premises, and personal planning.

Overall, the inspector saw that there were good risk management procedures in place in the centre. A risk register was in place to provide for the ongoing identification, monitoring and review of risk. This identified the control measures in place to deal with a number of risks within the designated centre. There was an organisational plan and risk assessments in place in relation to COVID-19. Where incidents occurred these were found to be appropriately recorded and considered. For example, a resident had recently been injured during seizure activity. Appropriate measures were taken by the management of the centre to ensure that this residents needs were being met and that appropriate medical input was sought by staff on duty if required. The resident was supported to access medical care and support and there were very comprehensive efforts taken to identify and collaborate with the residents medical team to reduce the frequency and severity of seizure activity.

As mentioned previously there was a significant physical intervention taking place on occasion for one resident during times when the resident presented a risk to themselves or others due to behaviours of concern. There was no evidence to suggest that this practice had been referred to, reviewed or approved, by a human rights committee as was the practice within this organisation. Although there was a risk assessment in place for this intervention, and the management of the centre provided rationale for it’s continued use, the risk assessment was not informed by review from an appropriate professional and therefore did not provide assurances as to the safety of this practice. There was also no evidence, beyond the opinion of management and staff, to show that this physical intervention was safe, the most appropriate, or the least restrictive practice that could be used. Staff were not trained in the use of this intervention, it had never been approved by an appropriate professional, and there was no evidence that the practice was safe for the resident or for staff that carried it out. A behaviour support professional had reviewed the resident following the last inspection in 2019 and there was significant input from multidisciplinary professionals such as a psychologist and psychiatrist. However, none of these professionals had approved the use of this particular intervention and none of them had visually seen or approved the intervention. While a referral to behaviour support specialists was made and some input received, management of the centre acknowledged that this input was not sufficient and cited the COVID-19 pandemic and the lack of a local behaviour support team as impacting on the availability of this resource. The management of the centre told the inspector that

some of the advice received from the behaviour specialist that had observed the individual had not been followed as the management of the centre had felt it was not suited to the individual and the required staffing resources were not in place to allow for this advice to be trialled.

There were other restrictions in place in the centre such as an electric gate that restricted residents from leaving the centre unsupervised, an alarm bell to alert staff if a resident exited the centre, the use of one-way viewing panes in one area of the centre, and the use of bus harnesses and other travel aids. These were in place to ensure the health and safety of the residents living in the centre and had been identified and reviewed as appropriate in the restrictive practice records in place in the centre. One resident preferred a minimalistic environment and had restricted access to some of their personal belongings such as clothing. However, there were clear efforts taking place to reduce some restrictions. For example, that resident had recently tolerated the gradual re-introduction of some of their clothing to their bedroom and the person in charge told the inspector about plans to expand on this in line with the residents assessed needs.

The person in charge and staff members spoken to talked about the importance of consistency within the staff team and how this was achieved to provide the best possible supports to all of the residents living in the centre. All staff working in the centre had received training in the 'Management of actual and potential aggression' (MAPA) and there were comprehensive positive behaviour support plans developed in conjunction with numerous health and social care professionals in place to guide staff in supporting individuals in a person centred manner that best suited their needs. In the case of one resident, this did not outline however, the most appropriate use of the physical intervention mentioned previously. The plan in place to support this individual however, did provide for alternative supports in place for the individual that reduced the need for the use of this intervention.

The inspector saw that residents were supported to make choices and that the staff in the centre knew them well and strove to meet their assessed needs. Support plans were in place that guided staff in this respect. However, the documentation around person centred plans was unclear and did not provide adequate guidance to staff about the goals that residents had or what steps were being taken to achieve them. The statement of purpose for this centre outlined that each individual would be supported to develop a person centred plan based on personal outcome measures that 'details the person's needs and outlines the supports required to maximise personal development and quality of life in accordance with their wishes.' While there was evidence of review of personal outcome measures for all residents, this was not carried through to reflect identified goals or evidenced in personal plans and these were not in a format that was accessible to residents. Two residents did not have person centred plans on file arising out of these reviews and one resident had a plan dated 2019. There was some evidence of goal setting in 2020 for one resident and limited review of same. However, the documentation was either incomplete or unclear and there was no evidence of formal goal setting occurring in the centre since that time. This had been identified also in an internal audit completed by the provider.

There were good infection control procedures in place in this centre. These were found to be in line with national guidance during the COVID-19 pandemic. The centre was visibly clean and appropriate hand-washing and hand-sanitisation facilities were available. Staff and management in the centre was using personal protective equipment (PPE) in line with national guidance. Staff had received extra training in recent months on infection control measures, including training about hand hygiene and how to use PPE correctly. Arrangements were in place for the appropriate screening of staff and residents on entering the centre and where a resident was availing of a shared care placement, arrangements were in place to mitigate against any risks posed by the COVID-19 virus, including the provision of isolation facilities if required.

Regulation 13: General welfare and development

Residents were observed to be relaxed and comfortable in their home and in the company of the staff that supported them. Residents were provided with opportunities for recreation and meaningful activities and staff were familiar with residents' preferences and communication styles. Family contact was facilitated and encouraged and residents were supported to celebrate important events in a meaningful way. There were efforts being made to enhance the quality of life of residents, such as amending the arrangements relating to shared care to better suit the needs of the individual availing of the service. Continuity of care was provided to residents and the future needs of residents was being considered and appropriate plans put in place.

Judgment: Compliant

Regulation 17: Premises

The premises was suitable to meet the needs of the residents. Resident bedrooms and living areas were decorated in a manner that reflected the individual preferences of residents. The centre was clean and there was a large garden area that residents had the use of. Overall, the centre was well maintained. However some internal and external painting was required and some areas of flooring required attention.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider had prepared a guide in respect of the designated centre and this was available to the resident. This guide contained all the required information as per the regulations.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had put in place systems for the assessment, management and ongoing review of risk. A risk register was in place to provide for the ongoing identification, monitoring and review of risk. Individual risks had been considered. There was clear evidence that there was learning from adverse incidents and the provider was proactive in their approach to risk management. An issue relating to the management of one physical intervention taking place in the centre is discussed under Regulation 23.

Judgment: Compliant

Regulation 27: Protection against infection

The registered provider had in place infection control measures that were in line with public health guidance and guidance published by HIQA.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider has put in place arrangements for detecting, containing and extinguishing fires and an appropriate alarm system was in place. The inspector was not assured that appropriate consideration had been given to assessing if two staff could safely evacuate all three residents in the event of an emergency in the centre, such as an outbreak of fire.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had not ensured that the recommendations arising out of

personal plan reviews was clearly recorded to include any proposed changes to the plans, the rationale for proposed changes and the names of those responsible for pursing objectives in the plans within agreed timescales. The documentation present did not provide adequate guidance to staff about the goals that residents had or what steps were being taken to achieve them. While there was evidence of review of personal outcome measures for all residents, this was not carried through to reflect identified goals or evidenced in personal plans and these were not in a format that was accessible to residents.

Judgment: Not compliant

Regulation 6: Health care

The person in charge had ensured that residents had access to an appropriate medical practitioner and recommended medical treatment and access to health and social care professionals was facilitated as appropriate. There was evidence that residents had accessed numerous multidisciplinary supports as required, including appropriate medical input and mental health supports. Residents were supported to attend appointments and there was evidence of ongoing review of residents health needs. Residents at this centre had access to numerous multidisciplinary supports, including psychiatry and psychology input as well as neurology and dietitian input.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge had not ensured that staff had up to date knowledge and skills to respond to behaviours of concern and support residents to manage their behaviour. There were some restrictions present in this centre. The person in charge not had ensured that, where restrictive procedures were used, they were applied in accordance with evidence based practice and the least restrictive procedure, for the shortest duration necessary was used.

Judgment: Not compliant

Regulation 8: Protection

The residents in this centre were protected from abuse. Suitable intimate care plans were in place to guide staff. Staff had received appropriate training in the safeguarding of vulnerable adults and the staff member spoke to and the person in

charge demonstrated a very good understanding and commitment to their responsibilities in this area.

Judgment: Compliant

Regulation 9: Residents' rights

The residents living in the centre was supported to exercise choice and control over their daily lives and participate in meaningful activities. Staff were observed to speak to and interact respectfully with the resident and were strong advocates for residents. There were arrangements in place for access to external advocacy services if required and residents were seen to be supported by staff and management in the centre to access this service. Resident's were supported to maintain family contact during the COVID-19 pandemic in line with public health guidance.

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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 32: Notification of periods when the person in charge is absent	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	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 Boherduff Services OSV-0005291

Inspection ID: MON-0033136

Date of inspection: 10/06/2021

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 15: Staffing</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 15: Staffing:
An application for funding for additional staffing resource has been prepared and submitted internally for costing. The completed business case for these additional resources will then be forwarded to the HSE, as funder, by the 03 August 2021 to ensure a sufficient number of staff on duty to meet residents' needs at all times. In the interim additional staffing will continue to be provided at times of anticipated need.</td></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The two identified new staff members completed their Fire Safety Training as scheduled on 23.06.2021.

Staff training records in relation to safeguarding training have been updated to ensure that they reflect all training undertaken.</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Not Compliant</td></tr>
</table>

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Services have engaged an external behaviour support agency to work with the Team around an identified need for an individual living in the centre. This agency will provide consultancy and training and support the establishment of a safe and appropriate specific behavioural intervention tailored to the individual's needs whilst respecting their rights. Staff training in advanced techniques has commenced as of 05 July 2021 and the external agency will be on site for consultation on 10 September 2021.

All future audits will undertake a review of interventions in place to ensure that the service provided is safe, appropriate to resident's needs and effectively monitored.

As per the compliance plan for Regulation 15: An application for funding for additional staffing resource has been prepared and submitted internally for costing. The completed business case for these additional resources will then be forwarded to the HSE, as funder, to ensure sufficient number of staff on duty to meet residents' needs at all times. In the interim additional staffing will continue to be provided at times of anticipated need.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Quotations for painting works are in the process of being sought and work is planned to commence by the end of August 2021.

The flooring in the sensory room and main bathroom are scheduled to be replaced commencing the week of 10 August 2021.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
A night time fire drill was completed on 05/07/2021 with the full participation of the individuals living in the house and with night time staffing only in place. This drill did not present with any difficulties and an exit time of 1 min and 20 seconds was recorded.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
All person centred plans have been updated to ensure that the recommendations arising from the most recent review of the plans are recorded to include proposed changes, the rationale for these changes and the individuals responsible for operationalising these plans. The plans further detail the steps required to be undertaken to achieve same whilst ensuring they are in a format that is accessible to the individuals concerned.

A meeting is scheduled with the Head of Learning, Development, Quality and Advocacy for 29 July 2021 to review and expand on the knowledge base of staff on the use of Person Centred Plans to support individuals to achieve their goals.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
As per the response to the compliance plan for Regulation 23: the Services have engaged an external behaviour support agency to work with the Team around an identified need for an individual living in the centre. This agency will provide consultancy and training and to support the establishment of a safe and appropriate specific behavioural intervention tailored to the individual’s needs whilst respecting their rights. Staff training in advanced techniques has commenced as of 05 July 2021 and the external agency will be on site for consultation on 10 September 2021.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	06/08/2021
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	23/06/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	03/09/2021

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	06/08/2021
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	30/07/2021
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	05/07/2021
Regulation 05(7)(a)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall	Not Compliant	Orange	29/07/2021

	be recorded and shall include any proposed changes to the personal plan.			
Regulation 05(7)(b)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the rationale for any such proposed changes.	Not Compliant	Orange	29/07/2021
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Not Compliant	Orange	29/07/2021
Regulation 05(8)	The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6).	Not Compliant	Orange	29/07/2021
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to	Not Compliant	Orange	10/09/2021

	behaviour that is challenging and to support residents to manage their behaviour.			
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.	Not Compliant	Orange	10/09/2021
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	10/09/2021