Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Ard na Greine
Name of provider:	Sunbeam House Services CLG
Address of centre:	Wicklow
Type of inspection:	Announced
Date of inspection:	27 March 2024
Centre ID:	OSV-0001689
Fieldwork ID:	MON-0033712

About the designated centre

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

Ard Na Greine is a designated centre operated by Sunbeam House Services Company Limited by Guarantee. The centre provides residential services to people who are fully ambulant, with moderate support needs. Residents are encouraged and supported to live as independently as possible within their local community. The designated centre can provide for a maximum of four adults with intellectual disabilities, of mixed gender who are over the age of 18 years. This designated centre was originally two houses that have been combined to become a large home with six bedrooms. The ground floor comprises a kitchen, sitting/dining room, a bedroom with en-suite bathroom and a utility room. Upstairs has four bedrooms, one sitting room, an office and two bathrooms. There is an enclosed garden space to the rear of the property. The staff team consists of social care workers and is managed by a full-time person in charge, with support of a deputy manager and senior manager. The person in charge, is also responsible for another designated centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Wednesday 27 March 2024	09:00hrs to 17:30hrs	Jacqueline Joynt	Lead

What residents told us and what inspectors observed

The purpose of this inspection was to inform a registration renewal recommendation for this designated centre.

The inspection was facilitated by the person in charge for the duration of the inspection. The inspector used observations and discussions with residents, in addition to a review of documentation and conversations with key staff, to form judgments on the residents' quality of life.

Overall, the inspector found that residents' rights were not being promoted at all times, that not all residents felt safe living in the centre and that not all residents' healthcare requirements were facilitated in a timely manner.

On the day of the inspection, the inspector was provided the opportunity to meet with three of the four residents. The inspector spoke with two residents, two family members and an external advocate as well as, staff and the local management team.

One of the residents informed the inspector that they did not feel safe in their home. They said that when there was shouting in the house in communal areas, they would go to their room and lock their door. The resident also informed the inspector that they would always lock their bedroom when they left the room as previously they had items taken from their room and that they did not feel it was safe to leave their door unlocked. The resident told the inspector that they had made a complaint but did not feel there was a satisfactory outcome.

Another resident expressed their unhappiness at living in the centre. They said they wanted to live in their own place; They wanted their own space. They told the inspector that they had previously engaged in potentially serious self-harm behaviour due to their upset about living in the house. The resident also relayed their upset of the new visitors' restrictions that were in place as it meant they could not have their friends come and visit them at night time. The resident said they had made complaints about some of the issues they were unhappy with about but, they had not been resolved yet. The resident informed the inspector that, alternative accommodation had been offered to them however, the accommodation was not suitable for them.

Family members relayed their concerns regarding the management of behavioural incidents that were occurring in the centre and in particular, at the weekends. There was a concern that not all staff were familiar with the supports in place to manage incidents. The family were also concerned about their relative locking themselves in their bedroom due to not feeling safe. They expressed how upsetting it was to receive a call and hear the residents upset during these times. Family also relayed concerns about destruction of property belonging to their relative and their belongings also going missing. They had relayed their concerns to management

however, felt that they were not resulting in adequate outcomes to reduce or mitigate risk of the recurrence of behavioural incidents.

The inspector also met with an external disability advocate for one of the residents living in the centre. On behalf of the resident, they had lodged a compliant to the provider. They were concerned about the quality of care and support provided to the resident, about the on-going psychological abuse the resident was enduring and lack of timeliness for the provider to find a suitable outcome. Overall, the advocate expressed their concern at the visible deterioration in the resident's mental and physical appearance within the last number of months.

Similar concerns were raised by staff who spoke with the inspector. They felt that the provider had not following up sufficiently, or in a timely manner, when staff and local management had previously raised concerns. They were concerned over delay in supporting a resident's health and in particular, regarding the equipment and facilities required for their personal care. Staff relayed concerns over high use of agency staff and the negative impact this was having on residents living in the house.

In advance of the inspection, residents and their families were provided with the option of completing Health Information and Quality Authority (HIQA) surveys. Three residents had completed the surveys. There was mixed responses in relation to the quality of care and support provided to residents.

Some residents relayed that their home was a nice place to live in while other residents did not agree with this statement. Not all residents felt people were kind to them in their home. Two of the three surveys noted that residents did not feel safe in their home. Some residents did not feel safe when they entered communal spaces in the house where there was likely to be other residents. Some residents mentioned that they had to lock their bedroom door as they did not believe their belongings to be safe and secure.

Most of the surveys relayed that staff members knew residents' likes and dislikes. However when asked, do staff help you when you need it, most residents noted 'it could be better' and that not all residents felt listened to. All residents noted that friends and advocates support them with their decision in their life. Two residents' surveys noted that they do not get along with the people they live with.

On entering the house the inspector observed the house to be bright and spacious. The house was clean and tidy and furnishing, wall art and the layout of communal areas presented as homely. The premises was originally two houses that had been combined to become a large home. The ground floor comprised a kitchen, sitting/dining room, a bedroom with en-suite bathroom and a utility room. Upstairs had three bedrooms, one sitting room that was specifically provided for one resident only, two offices (one doubled as a sleepover room) and two bathrooms. There was an enclosed garden space to the rear of the property where residents could sit out in the summer-time if they so wished.

On the day of the inspection, the inspector observed that residents seemed relaxed and happy in the company of staff that were working on the day. The inspector

observed that that staff were respectful towards residents through positive and caring interactions. During conversations with the inspector, staff advocated on behalf of residents and also empowered residents to advocate for themselves. However, during conversations with residents, the inspector found that not all residents felt comfortable in the company of all staff as they felt they did not know them well enough and that it could take a while to get to know all the staff.

On review of a sample of residents' personal plans the inspector saw that the plans demonstrated that for the most part, residents were facilitated and encouraged to engage in their communities in a meaningful way.

The inspector found that most residents were assisted to experience a full range of relationships, including friendships and community links, as well as personal relationships. Residents were engaged in their local community through many different social activities. One resident informed the inspector that they volunteer in two locations twice a week. Another resident was actively seeking employment and had a job coach assigned to help them in their search. Another resident was attending a community day service on a full-time basis.

Residents were provided with a choice of healthy meal, beverage and snack options which were recorded in their personal plan. Treats were also available to residents such as take-out meals and a wide variety of healthy snacks. However, the inspector found that the health and wellbeing of each resident was not always promoted and supported in line with their assessed needs.

Due to the changing needs of a resident since October 2023 they required considerable supports in relation to their manual handling and healthcare needs. The timeliness of the provider to ensure the centre was supplied with appropriate manual handling aids and devices to support the resident's mobility and manual handling requirements was not satisfactory. In particular, the timeliness for shower facilities to be supplied and fitted with various assistive aids as well as providing aids and appliances that supported the resident's personal hygiene and intimate care needs, was not satisfactory and overall was impacting on their independence, privacy and dignity.

In summary, the inspector found that overall, through speaking with residents and staff, through observations and a review of documentation, that, residents lived experience in the designated centre was not always positive. For some residents this was primarily due to the continuous behavioural incidents occurring in the house and the how it impacted on them. In addition, residents' rights were not being fully promoted in the centre and in particular, in relation to their safety, health and wellbeing, independence, privacy and dignity.

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 to each resident living in the centre.

Capacity and capability

The inspector found that management systems in place did not adequately ensure that the service provided was safe, appropriate to all residents' needs and effectively monitored, at all times. There was an increase of non-compliance found on this inspection compared to the last inspection in May 2023 and in some cases, continuance of non-compliance. For example, the provider had not complied with regulations relating to staffing, protection, healthcare, governance and management and notifications of incidents, and a number of actions were required to bring them back into compliance. Overall, the inspector found that, the provider was not operating the centre in a manner that ensured residents were living in a safe environment and that their rights were respected at all times.

There were ongoing behavioural incidents occurring in the house which impacted negatively on the lives of residents, and had resulted in residents feeling unsafe in their own home. In addition, not all residents felt they were living in a suitable environment that met their needs and in particular, in relation to independent needs. Both these issues had been raised on previous inspections of the centre since June 2022 and despite numerous strategies and plans put in place, there had been no satisfactory outcome that provided a better lived experience for the residents to date.

In addition, due to the rapid changing healthcare needs of a resident, specialised equipment and facilities to support the resident's needs had been recommending by an allied healthcare professional. However, the timeliness of the provider to install some of the equipment for the resident was not satisfactory and was negatively impacting on a number of the resident's rights including privacy, dignity and personal care.

Furthermore, in the last twelve months, the Chief Inspector had received unsolicited information about the centre on five occasions. The information set out concerns about the quality of care and support provided to residents. The provider was requested to submit written assurances to the Chief Inspector in response to these concerns received. The assurances provided had not been effective or had since been withdrawn in some instances.

There was a new person in charge employed in the centre in February 2024 and they were supported by a deputy manager (both who divided their hours between this centre and another location). During a period in 2023, when the previous person in charge was absent, the provider had not ensured adequate management arrangements were put in place in line with the regulatory requirement.

The governance and management systems in place, to ensure that the service provided was consistent and effectively managed, were not effective. A number of provider led audits relating to the care and support provided to residents healthcare, safeguarding and medicines had not ensured shared learning, sustained

improvements or appropriate actions and timelines.

The registered provider was not resourcing the designated centre effectively. The provider continued to be reliant on the use of external agency staff to operate the centre. There were six and half (whole time equivalent) social care worker vacancies.

While the person in charge was endeavouring to ensure continuity of care employing the same agency staff as much as possible, regular dependence on agency and relief staff, impacted on the effectiveness of the continuity of care provided to residents and in particular, in relation to their medical needs, behavioural support needs, their safety and continuity of care.

The inspector carried out a review of a sample staff information and documents specified in Schedule 2 and found that they were all in place and maintained appropriately.

There was a system in place to evaluate staff training needs and to ensure that adequate training levels were in place. A training matrix was maintained by the person in charge, which demonstrated that staff were provided with both mandatory and refresher training. The person in charge monitored the training needs of the staff on a regular basis as well as training completed by agency staff. The person in charge had been proactive in sourcing a number or training courses that would better enhance staff skills in supporting the changing needs of some residents.

The provider had not ensured that the information governance arrangements in place in the designated centre were effective in ensuring they complied with notification requirements. Where alleged safeguarding incidents and serious injuries had occurred, the provider had not submitted the required notification to HIQA. This non-compliance had been identified on two previous inspections of the designated centre however, the actions to rectify the issue were not sustained.

Regulation 14: Persons in charge

The person in charge divided their role between this centre and another location. The inspector found that the the person in charge had the appropriate qualifications and skills and sufficient practice and management experience to oversee the residential service to meet its stated purpose, aims and objectives.

The person in charge had completed fitness assessment with the inspector in March 2024 and had been assessed as fit.

Within a short period of working in the centre, the person in charge had becoming familiar with residents needs and supports in place to meet those needs. In addition, the person in charge had been proactive in following up and progressing a number of allied healthcare recommendations, which had been outstanding since August

2023.

Judgment: Compliant

Regulation 15: Staffing

Improvements were needed to ensure that the number of staff employed was appropriate to the residents assessed needs and that continuity of care was provided to residents. For example, during three weeks in March 2024 the roster demonstrated that on average that the same ten to thirteen agency staff were employed per week.

The person in charge was endeavouring to provide continuity of care by employing the same agency staff as much as possible and since early March, two new full-time permanent staff had been employed. In addition, the same three part-time relieve staff were employed as much as available.

The roster in place required some improvements to ensure that it was maintained appropriately. For example, the deputy manager's hours had not been recorded on roster for March 2024. The person in charge's hours had not been accurately reflected on the roster and there was no distinction made on the roster between full-time permanent staff and relief staff.

Judgment: Not compliant

Regulation 16: Training and staff development

There was a system in place to evaluate staff training needs and to ensure that adequate training levels were maintained.

All staff had completed or were scheduled to complete the organisation's mandatory training including fire safety, manual handling, safe medication practices, safeguarding and infection prevention and control training (IPC) but to mention a few.

Furthermore, specific training and support was offered to the team in order to support residents changing needs. Staff were provided bespoke mental health and positive behaviour support training. In addition, the person in charge had been proactive in organising training in Food and Drink (FEDS) and Dementia, to ensure staff have the appropriate skills when supporting the changing needs of residents.

Since commencing their role, the person in charge had carried out a supervision meeting with all permanent staff in the centre.

Judgment: Compliant

Regulation 23: Governance and management

The timeliness of the provider finding alternative accommodation for a resident, who has express their will and preference to move location, was not satisfactory. Actions and timelines submitted to the Chief Inspector in a written provider assurance report, whereby a resident was being supported to move into a new location in December 2023, had not come to fruition. The accommodation sourced did not meet the resident's needs and since then no other accommodation has been sourced by the provider.

The provider was not meeting the assessed healthcare needs of all residents; recommendations made in August 2023 had not been completed. On the day of the inspection, there was no adequate plan in place or timelines to complete the work to a residents bathroom facility. The inspector was advised that an application to vary was needed for a location the resident would temporally need to move to however, the application had not yet been submitted to the Chief Inspector.

Despite assurances provided less than 21 months ago after a regulatory escalation meeting and warning letter issued to the provider, the provider was continuing to fail to bring a number of regulations back in to compliance (regulation 8, 23 and 31). Many of the non-compliance findings on this inspection were similar previous non-compliances found.

The governance and management quality assurance systems in place were not effective, at all times. While the provider had completed a six monthly unannounced review of the quality of care and support provided to residents, the action place was not effective as there was no plan or time-line in place to complete the actions identified by the review.

In addition, issues identified the centre's 2023 medication audit had not been appropriately followed up. Where insufficient record keeping had been noted for self-medication, this issue arose again in the 2024 audit. Oversight systems in place for potential and actual safeguarding concerns where not always effective. Furthermore, the provider's governance and management arrangements in place, to ensure all required notifications were submitted, was not effective in ensuring they were in line with the regulation requirement.

The provider had not ensured that the organisation's safeguarding policy, to ensure safe and effective care is provided to residents including, guiding staff in delivering safe and appropriate care, was effectively reviewed and within time-lines they had previously committed to.

Judgment: Not compliant

Regulation 31: Notification of incidents

Governance and management oversight of notification systems not adequate.

Not all incidents were appropriately managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence.

Since February 2024, ten notifications relating to safeguarding incidents, two of which were of a high level of risk, were not submitted within the time frame as set out in the Regulations which is three days.

For example, some notifications related to incidents that had occurred between 30 and 98 days previous to being notified. In addition, not all incidents and concerns had not been followed up in line with the National Safeguarding of Vulnerable Adults policy and procedures. As such, appropriate screening, investigation, follow-up and shared learning was delayed and meant that there was a high risk of recurrence of the same incidents.

Three notifications relating to incidents where injuries require emergency or medical treatment were not submitted within the three day required time-frame. For example, some were submitted between 34 and 98 days after an incident. In some cases, where there had been a serious injury to a resident that required hospital care a notification had not been submitted at all to the Chief Inspector as required.

Quarterly notifications required for restrictive practices and non-serious injuries had not been submitted by to the Chief Inspector for Quarter four of 2023 despite such practices in place in the centre and minor injury incidents recorded in the centre.

Judgment: Not compliant

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent

When the previous person in charge was absent for a period of two months in 2023, the provider submitted a notification for the absence however, the person the provider nominated did not meet the requirements of Regulation 14. For example, they did not have a minimum of 3 years' experience in a management or supervisory role in the area of health or social care.

This meant that there was no appropriate interim person in charge in place during this period. Overall, the provider had not ensured that the procedures and arrangements in place during the time of the person in charge's two month absence was adequate.

Judgment: Not compliant

Regulation 34: Complaints procedure

The registered provider had a complaints procedure in place that was easily accessible to residents.

There was an easy read document on how to make a complaint on the centre's notice board. There was also information regarding the national advocacy service available to residents.

The annual review noted that ten complaints had been made over a twelve month period. The complaints primarily related to behavioural incidents. The six monthly noted four complaints made and as on the day of the inspection, two of the complaints remained open as they had not yet been resolved.

Overall, the timeliness to resolved all complaints was not always satisfactory. In addition, not all complaints noted satisfactory levels from complainants.

Judgment: Substantially compliant

Quality and safety

The inspector found that, the governance and management arrangements in place, which impact on the quality and safety of care and support provided to residents living in the centre, were not adequate and were resulting in negative outcomes for residents living in the centre. There was an ongoing risk to the health, safety and wellbeing of residents living in the designated centre.

The provider had failed to ensure that all residents were protected from all forms of abuse at all times. In addition, not all residents' assessed healthcare needs were being met at all times. Residents expressed their unhappiness of living in the designated centre; not all residents felt safe in their home, or believed that their personal possessions were secure. The provider had been made aware of the situation however, their timeliness in finding a satisfactory outcomes was not adequate and resulted in a negative lived experiences for three of the four residents.

The safeguarding policy in place was not adequate. The arrangements in place in the centre did not ensure that when potential safeguarding risks were raised by staff, that they were reviewed, screened, escalated, investigated in accordance with national safeguarding policy at all times. Overall, the continuation of behavioural incidents that was resulting in psychological abuse was impacting on the physical

and mental health of residents.

Appropriate healthcare was not always made available to residents having regard to their personal plan. The provider had not ensured that all residents received support at times of illness which met their physical, emotional needs and respected their dignity, rights and wishes. While residents' healthcare plans demonstrated that each resident had access to allied health professionals including access to their general practitioner (GP), recommendations made by allied health professionals, and in particular, relating to required equipment and facilities, were not always followed up in a timely manner. This impacted negatively on the physical and emotional health of residents as well as residents' right to privacy and dignity relating to their personal care.

In addition, not all residents healthcare needs had been appropriately reviewed which meant that not all required supports were in place for them, and in particular, in relation to their safe administration of medicine supports. The systems in place had not been effective in identifying that all medicines prescribed to a resident were being safely managed in line with best practice and within the organisation's policy.

The provider had ensured that the risk management policy met the requirements as set out in the regulations, however, practice was not in line with the policy at all times. Improvements were needed to ensure that the systems in place, to manage, mitigate and review risks were effective. This was to ensure the safety of residents and staff. The inspector found that the arrangements for the identification, recording and investigation of, and learning from serious incident and adverse events involved residents were not satisfactory at all times.

All residents were provided with a personal plan. For the most part, plans were reviewed annually, in consultation with each resident, and more regularly if required. Where appropriate, residents were provided with an accessible format of their personal plan.

Staff had completed specific training in relation to infection, prevention and control. From a review of relevant audits and cleaning checklists, the inspector found that staff were working in line and adhering with, the cleaning schedules in place. Overall, the premise was in good upkeep and repair and was observed to be clean and tidy.

The provider and person in charge promoted a positive approach in responding to behaviours that challenge and ensured evidence-based specialist and therapeutic interventions were implemented. Systems were in place to ensure that where behavioural support practices were being used that they were clearly documented and reviewed by the appropriate professionals on a regular basis and more often if required.

There was a number of environmental and rights restrictive practices used in the centre. Primarily the restrictions were in place to support the health, safety and wellbeing of residents living in the centre. For the most part, where applied, the restrictive practices were clearly documented and were subject to review by the appropriate professionals. However, improvements were needed to ensure that all

restrictions in place, and in particular, restrictions relating to visitors, were supported by an appropriate risk assessment and were applied in accordance with national policy and evidence based practice.

Residents expressed themselves through their personalised living spaces. The residents were consulted in the décor of their rooms which included family photographs, paintings and memorabilia that were of interest to them. Due to the changing healthcare needs of a resident, the current design and layout of an en-suite bathroom did not ensure that the resident could avail of an accessible bathroom facility. This impacted negatively on the resident's right to independence, privacy and dignity.

Regulation 26: Risk management procedures

The person in charge had recently reviewed and updated the risk register and associated risk assessments as well as including a table that, clearly demonstrated the risk in place for each resident and a colour coded level the risk presented.

There were a number of personal risks which had been assessed as high level for each resident living in the house; Some of the risks related to abuse in their home, occurrence of behavioural incidents, allegations and decline in health.

While the provider had identified the risk, suitably assessed them as high level risks, the control measures to reduce the risk remained outstanding, for example, one control measure identified was the provision of alternative accommodation and allied healthcare recommendations.

This meant that overall, the risk register was not being used as tool to drive quality improvement in implementing measures to mitigate against known risks in a timely manner.

In addition, as a number of serious injuries and safeguarding incidents had not been followed up appropriately, it meant that the practice in place for the identification, recording and investigation of, and learning from serious incident and adverse events were not in line with the provider's risk management policy.

Some of the above matters relating to risk have also been referred to in Regulations 6, 8 and 23.

Judgment: Substantially compliant

Regulation 27: Protection against infection

There was an up-to-date comprehensive policy relating to infection, prevention and

control in the designated centre and it was made availabe to all staff.

The inspector found that the infection prevention and control measures were effective and efficiently managed to ensure the safety of residents.

The inspector observed the house to be clean and that cleaning records demonstrated a high level of adherence to cleaning schedules.

Staff had completed specific training in relation to the prevention and control.

Judgment: Compliant

Regulation 6: Health care

The provider had not ensured that all residents received support at times of illness which met their physical, emotional needs and respected their dignity, rights and wishes. In addition, the provider had not ensured that appropriate healthcare was provided at all times, for all residents, having regard to their personal plan.

A resident's health had significantly declined since August 2023. The timeliness of completing recommendations by an allied health professional was having a negative impact on the resident.

Recommended equipment to support a resident's changing healthcare needs such as an over-bed table, bed leaver and drop down toilet rails were installed seven months after the recommendation. This meant that when the resident was using the toilet facility they had to be supervised by staff.

In addition, updated recommendations to provide a shower facility that would meet the changing healthcare needs of a resident, had not yet been installed. This meant that the resident was currently only provided bed-baths. There was no satisfactory plan or timeline in place for this work to be completed.

Furthermore, where a resident was prescribed daily medication during a period from March 2023 to March 2024, there had been no appropriate systems in place to facilitate the safe administration, storing or review of the medication. When this was identified on the provider's 2024 medication audit the person in charge promptly follow up and ensured all correct procedures were in place and that the resident's healthcare self-medication assessment and associated support plans were updated as appropriate.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Where appropriate, residents were provided with positive behavioural support plans and these were regularly reviewed and updated. Staff were informed of the plan and provided bespoke training to support their understanding of the guidelines within the plan.

In addition to positive behaviour supports provided by the organisation, the provider had made arrangements for an external positive behaviour specialist to assessed the needs of one resident. The assessment was to determine the most appropriate living environment and level of supports required for the resident. This was to ensure that any alternative accommodation offered to the resident would be adequately suitable for them.

There was a short-term restrictive practice in place that restricted residents having friends visit their home in the evening time.

While a rationale had been put forward to the organisation's rights committee, there had been no appropriate risk assessment completed in advance of the commencement of the restriction.

This was not in line with the provider's own policies and procedures and national standards and was having a negative impact on residents. Residents expressed their unhappiness about this arrangement to the inspector during the course of the inspection.

Judgment: Substantially compliant

Regulation 8: Protection

Behavioural incident occurring in the centre were at times, resulting in safeguarding incidents. Current strategies in place to reduce the incidents occurring were not always effective. Without further intervention, the inspector could not be assured that residents were protected from all forms of abuse at all times. Residents remained at risk and their quality of life was being impacted upon in their own home.

Not all safeguarding incidents had been reported in line with the national safeguarding policy and procedures or within the regulatory requirement. Since February 2024, ten 'issues of concern' had been identified and reported as alleged safeguarding incidents. The incidents had occurred, on average, between 30 and 60 days prior to being notified to both the safeguarding team and the Chief Inspector. This meant that not all safeguarding incidents had been appropriately screened, investigated or reported as required and posed an increased safety risks to residents living in the centre.

The organisation's safeguarding policy was not comprehensive in nature and did not adequately demonstrate that it was written for the service, clear or easily accessible.

While the policy referred to other legislation and professional guidance, including national safeguarding policy, it had not adopted the information adequately into the policy to ensure its effectiveness in guiding staff in delivering safe and appropriate care to residents.

The provider had committed to reviewing the policy in December 2023 however, this had not been completed. In addition, the review of the safeguarding procedures was outstanding as the review was due in January 2023.

Judgment: Not compliant

Regulation 9: Residents' rights

The centre was not being operated in a manner that was respectful of all residents' needs and rights.

Strategies in place to reduce the risk of safeguarding incidents occur were restrictive in nature. For example, strategies that required staff supervision of residents during times there was more than one resident in a communal areas in the house and visiting restrictions.

While these initiatives were somewhat effective, the arrangement was impinging on residents' rights to exercise choice, freedom and control in their daily lives.

A number of complaints relating to safeguarding remained unresolved. Complaints demonstrated a consistent theme relating to residents rights regarding their privacy and living space and ultimately the right to feel safe in their own home.

Not all residents wanted to live with other residents living in their home. Due to the nature of the incidents and their frequency demonstrating the implementation of a rights-based approach to care was proving challenging in the centre and improvements were required.

Not all residents' right to feel safe in the their home was promoted; residents felt anxious and unsafe for a number of reasons, in particular, due to the staffing arrangements in place, the management of on-going behavioural incidents and security of their personal possessions.

Due to ongoing behavioural incidents and the changing needs of a resident, residents' right to have visitors in their home, was restricted.

Not all residents' privacy and dignity in relation to their intimate and personal care were promoted.

Not all residents' rights to be provided with appropriate equipment and facilities that supported their assessed needs was promoted.

Judgment: Not 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	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Ard na Greine OSV-0001689

Inspection ID: MON-0033712

Date of inspection: 27/03/2024

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: There is currently one permanent 120 hour CSW vacancy in the location and one specified purpose 110 hour CSW to cover Leave of Absence. A relief panel has been established to mitigate the reliance on agency staff locally, resulting in the appointment of two relief staff employed by the organization for this centre. Whenever feasible, regular agency staff is used to maintain consistency in the delivery of care. Due to the increasing needs of the resident a business case has been submitted to the funder in November 2023 for 5 WTE. Currently awaiting outcome. There is also a business case submitted for extra staff in evening time to support the resident to mitigate negative peer to peer interactions totaling 1.5 WTE. In the meantime, these posts are being filled with agency/relief staff members. SHS took part in the Job Fair in the RDS in March 2024 to attract more staffing. Roster has been updated to accurately reflect the distinction between permanent and relief staff designated centre. Deputy CSM hours are also reflected on the roster. Complete: 15/04/2024	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management: Timeliness to find Accommodation The provider is liaising with Local housing body in order to obtain a suitable property for resident who wishes to move to a different location. SHS engaged on the 7th of February 2024 with a Psychology and applied behaviour analysis specialist to undertake the following: • Complete an observational assessment and review of current support plans. • Provide advice and recommendations on support plans and staff development in relation to the plans. • Provide recommendations on support needs going forward in relation to potential alternate living environments for the resident. An initial meeting was held on the 29th of February 2024 with the external behaviour specialist. PIC submitted requested documentation on the 1st of March 2024. The external behaviour specialist met with the resident on the 8th of March 2024. The assessment was completed on the 3rd May 2024. Once assessment and recommendations are reviewed, a business case will be submitted to the funder to request the appropriate staff identified by the behaviour specialist to facilitate the resident living in alternative accommodation. This will be submitted by the 31st of May 2024. A potential apartment has been identified for the resident. The provider has placed an offer on the property on the 30th of April. Currently awaiting a response from seller. An environmental assessment will be completed by OT and the staffing recommendations of the external behaviour specialist will also be taken into consideration. This will determine the suitability of the property for the resident. Healthcare Needs Bathroom to be converted to wet room. Work will begin on the 27.05.2024 and be completed by 30th of June 2024. The resident with changing healthcare needs will move to a different property for the duration of the works. Application to vary will be submitted prior to the commencement of the works. Resident is regularly reviewed by GP, also availing of OT and physiotherapy support as required. MDT meeting held on the 28th of March, including resident's GP to explore supports required. Recommendations have been implemented. Actions Outstanding from Previous compliance plan: Regulation 23: Governance and Management. An interim full-time PIC with an interim deputy manager are in place to oversee and	

manage the complexities of the location while the permanent PIC in on leave. For a short period of time the PIC and deputy manager will also cover a second location as one client will move temporarily so that work can be completed in the ensuite bathroom.

Regulation 8: Protection

The person in charge is now ensuring that incidents are submitted within the correct timeframe. All notifications up to date including NF06 and NF03 02/04/2024. All notifications will be completed in timely manner by Person in charge.

A Safeguarding Liaison position is being advertised by the provider to increase oversight of safeguarding concerns that may arise.

Regulation 31: Notification of Incidents

The person in charge is now ensuring that incidents are submitted within the correct timeframe. All notifications are now up to date including NF06 and NF03 02/04/2024.All notifications will be complete in timely manner by Person in charge.

6 Monthly Provider Audit Action Plan
The 6 monthly provider audit action plan was updated on the 27.03.2024 and will be regularly updated by the PIC thereafter with SMART plans.
Updated on 27.03.2024 with the following updates:
Medication Audit and Oversight

All medication issues that were highlighted by audit were addressed by person in charge and correct systems re: storage and administration of medication is in place as of 22.03.2024.

Local management regularly review and complete spot checks of medication to identify gaps and errors.

Notifications

The person in charge is now ensuring that incidents are submitted within the correct timeframe. All notifications are now up to date including NF06 and NF03 02/04/2024. All notifications will be complete in timely manner by Person in charge.

Safeguarding

• PIC completes a preliminary screening form each time a safeguarding concern arises and submits to National Safeguarding team and relevant HIQA notifications are submitted.
• Updated formal safeguarding plan submitted to National Safeguarding Team on 15.04.2024 in relation to peer to peer abuse.

• PIC in regular contact with National Safeguarding Team to keep them updated and informed of any changes to safeguarding plans.
• MDT meeting regarding resident who has had significant safeguarding concerns has taken place on 25.04.2024.
• External Behaviour Specialist met with resident who is expressing wish to move house on 08.03.2024 and has completed a report on future service for resident 03/05/2024.
• Behaviour Support Specialist continues to provide support to resident. Met with resident on 17.04.2024.
• Safeguarding policy and procedure will be updated by the 31st of May 2024.
• A Safeguarding Liaison position has been advertised to oversee safeguarding concerns within the organisation.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Person in charge updated notifications when role taken up in February 2024. Last back dated notification completed on 02.04.2024.

The person in charge is now ensuring that incidents are submitted within the correct timeframe. All notifications are now up to date including NF06 and NF03 02/04/2024. All notifications will be complete in timely manner by Person in charge.

Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent	Not Compliant

Outline how you are going to come into compliance with Regulation 33: Notifications of procedures and arrangements for periods when the person in charge is absent:
An interim full-time PIC with an interim deputy manager are in place to oversee and manage the complexities of the location while the permanent PIC in on leave. For a short period of time the PIC and deputy manager will also cover a second location as one client will move temporarily so that work can be completed in the ensuite bathroom.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The provider endeavors to close complaints in a timely manner. However, the ongoing safeguarding concern requires a resolution which means that one resident needs to move house. This is being actively worked on through the following:

The provider is liaising with Local housing body in order to obtain a suitable property for resident who wishes to move to a different location.

There are currently four open complaints. Three of these relate to one resident being happy with peer issues in relation to challenging behaviour and compatibility issues between the two residents. Meetings regarding resident's complaint took place on 05.03.2024 and next meeting to take place on 08.05.2024 with family and advocacy representatives present.

The fourth complaint relates to one resident who is unhappy in her residential placement and would like to move. The report from behaviour specialist in relation to the most suitable service that should be established for this resident was completed on the 03.05.2024. Once assessment and recommendations are reviewed, a business case will be submitted to the funder to request the appropriate staff identified by the behaviour specialist to facilitate the resident living in alternative accommodation. This will be submitted by the 31st of May 2024.

There are local plans in place to reduce the risk of incidents occurring leading to complaints from residents, family and advocacy representatives. Where complaints are logged, meetings are being planned with stakeholders to discuss issues and try and reach resolution.

Advocacy is available to all residents and some residents communicate with advocate on regular basis.

Social Worker available to all residents and regularly involved.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Risks in the centre relating to compatibility are being actively pursued on in order to

relocate one resident to a more suitable location.

Other risk relates to healthcare needs of one resident who requires a wet room. To date this resident has received a new profile bed and mattress, bed rail now in place as control measure for falls risk. Person in charge is regularly liaising with clinical team to ensure best possible health for resident. Wet room to be completed for resident's accessibility on 30th of June 2024. which will further mitigate risk.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
The person in charge will endeavour that all medical treatment necessary for resident's quality of life will be facilitated. Ongoing Multidisciplinary team meetings are being held for one resident who has declining health. The last meeting was held on 28.03.2024 and all recommendations will be completed by the 30th of June 2024.

Extra staffing has been put in place for one resident whose health is declining in the form of 1:1 staff support.

The following required equipment has been sourced as per MDT recommendations:

• Bespoke wheelchair delivered on 27.03.2024.
• Wet room to be completed by 30th of June 2024.

The concerns highlighted following an internal medication audit have been addressed. All necessary documentation and assessments are now in place. The resident has been fully consulted on all measures implemented. 17/04/2024

Local management completes regular spot checks on medication documentation and stock to provide additional oversight.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Short term restriction regarding visitors has been lifted as of 02.04.2024. This was only in place for a period of one month since 05.03.2024 in order to protect other residents in the house due to increase of concerns documented. Person in charge will ensure that

any future restrictions have a robust risk assessment to provide outline of rationale.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Person in charge will ensure all incidents are reported to appropriate authorities within the allocated timeframes. Person in charge will ensure that appropriate processes take place when there is an issue of concern.

Extra staffing has been put in place for one resident whose health is declining in the form of 1:1 staff support.

PIC completes a preliminary screening form each time a safeguarding concern arises and submits to National Safeguarding team and relevant HIQA notifications are submitted.

Updated formal safeguarding plan submitted to National Safeguarding Team on 15.04.2024 in relation to peer to peer abuse.
PIC in regular contact with National Safeguarding Team to keep them updated and informed of any changes to safeguarding plans.
As referenced in Regulation 23, the provider is exploring alternative accomodation options and the support required for one resident to relocate.
All residents have access to advocacy support and a number of residents are in regular contact with their advocate. All residents have access to Social Work support and two residents avail of this social work support weekly.
Meeting regarding resident feeling unhappy in house due to incompatibility concerns took place on 05.03.2024 and next meeting to take place on 08.05.2024 with family and advocacy representatives.
Safeguarding policy and procedure will be updated by the 31st of May 2024.
A Safeguarding Liaison position has been advertised to oversee safeguarding concerns within the organization.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Short term restriction regarding visitors has been lifted as of 02.0.2024. This was only in place for a period of one month since 05.03.2024. Any further restrictions to be implemented will have robust risk assessments to support them.

Privacy and dignity for one resident is being addressed by upcoming works on bathroom

which will be converted to a wet room. Works will begin on the 27.05.2024 and to be completed by 30th of June 2024.

All residents have access to advocacy support and a number of residents are in regular contact with their advocate. All residents have access to Social Work support and two residents avail of this social work support weekly.

As referenced in Regulation 23, the provider is exploring alternative accommodation options and the support required for one resident to relocate.

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.	Not Compliant	Orange	01/12/2024
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	01/12/2024
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Not Compliant	Orange	31/03/2025

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
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	31/03/2025
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Substantially Compliant	Yellow	31/03/2025
Regulation 26(2)	The registered provider shall ensure that there	Substantially Compliant	Yellow	03/05/2024

	are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	02/04/2024
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	02/04/2024
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each	Not Compliant	Orange	02/04/2024

	calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 33(1)	Where the registered provider gives notice of the absence of the person in charge from the designated centre under Regulation 32, he or she shall give notice in writing to the chief inspector of the procedures and arrangements that will be in place for the management of the designated centre during the said absence.	Not Compliant	Orange	03/05/2024
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Substantially Compliant	Yellow	31/03/2025
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any	Substantially Compliant	Yellow	31/03/2025

	action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	30/06/2024
Regulation 06(2)(b)	The person in charge shall ensure that where medical treatment is recommended and agreed by the resident, such treatment is facilitated.	Substantially Compliant	Yellow	30/06/2024
Regulation 06(2)(d)	The person in charge shall ensure that when a resident requires services provided by allied health professionals, access to such services is provided by the registered provider or by arrangement with the Executive.	Not Compliant	Orange	30/06/2024
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	Substantially Compliant	Yellow	02/04/2024

	evidence based practice.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/03/2025
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	31/03/2025
Regulation 09(1)	The registered provider shall ensure that the designated centre is operated in a manner that respects the age, gender, sexual orientation, disability, family status, civil status, race, religious beliefs and ethnic and cultural background of each resident.	Not Compliant	Orange	31/03/2025
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships,	Not Compliant	Orange	31/03/2025

	intimate and personal care, professional consultations and personal information.			