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: | Bantry Residential |
| Name of provider: | CoAction West Cork CLG |
| Address of centre: | Cork |
| Type of inspection: | Announced |
| Date of inspection: | 03 June 2022 |
| Centre ID: | OSV-0002105 |
| Fieldwork ID: | MON-0028040 |

## About the designated centre

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

This designated centre consists of four houses in a rural town setting. Each of the houses contain a kitchen, sitting room, single bedrooms, bathroom facilities and outdoor areas and gardens. The centre provides residential and respite services for up to 17 people, aged over 18 years. Residents are both male and female, with a diagnosis of intellectual disability. Staff support is provided by social care workers / leaders and support workers.

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

| | |
|---|---|
| Number of residents on the date of inspection: | 8 |

## 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 |
|---|---|---|---|
| Friday 3 June 2022 | 08:50hrs to 20:20hrs | Caitriona Twomey | Lead |

## What residents told us and what inspectors observed

The centre was comprised of four houses and was registered to accommodate 17 adults. Seven residents lived in the centre on a full-time basis and a respite service was provided in 10 bedrooms. The four houses were located near to a coastal town in County Cork. A respite only service was provided in two adjacent houses. Both of these houses were registered to accommodate three residents. Another house was registered to accommodate five residents. This was made up of three residential placements and two respite bedrooms. The fourth house was registered to accommodate six residents. A full-time residential service was provided to four residents and a respite service was provided in two bedrooms. At the time of this inspection, the respite services provided in each of the four houses were operating at a reduced capacity due to staffing shortages.

There were eight residents staying in the centre on the day of the inspection and the inspector spent time with each of them. This was an announced inspection. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and all staff adhered to these throughout the inspection.

The inspector initially visited the two adjoining houses that provided a respite service. Each of these houses had one ground floor bedroom, with an ensuite bedroom, that could accommodate a wheelchair user. These houses also had a sitting room, a kitchen and dining room, a utility room, three upstairs bedrooms and a shared bathroom. At the time of this inspection, no services were being provided in one house. Until the month prior to this inspection, one resident had been staying regularly in this house from Monday to Thursday. Their bedroom had been decorated with their name and personalised in line with their individual tastes. Due to staffing shortages, they were now accessing a respite service in one of the larger houses in this designated centre. The inspector did not meet with this resident as they were not staying in the centre at the time of this inspection. When in this house, some areas in need of repair were identified. These will be outlined in the 'Quality and safety' section of this report.

In the other house, respite was provided from Monday to Friday, on alternate weeks, to the same two groups of residents. One week two residents stayed and the following week a group of three residents stayed in this house. The inspector met with two residents who were returning to their family homes later that day. One resident was supported to go for a walk in the local area and was later engaged in a preferred activity while sitting at the kitchen table. The other resident was relaxing in their bedroom and spoke briefly to the inspector. Both residents appeared at ease in the centre and with the staff support provided to them.

While in this house, the inspector observed the use of door stops or other items to keep doors from closing on three separate doors. As a result, if required in the event of a fire, these doors would not be able to close and prevent the spread of smoke

and gases. The person in charge requested that these be removed immediately. It was also noted that the safe used to store residents' finances was open and unlocked. This was not keeping with the provider's own policies and procedures, some of which had been developed following the discovery that money belonging to one resident was missing in December 2020.

When discussing the residents who accessed respite in this house, it was identified that one resident ordinarily accessed respite in another designated centre run by the provider in a town approximately 50 kilometres away. That centre had closed at the beginning of the COVID-19 pandemic and had not re-opened since due to staff shortages. This resident's contract of care with the provider was reviewed and will be discussed in the next section of this report.

The inspector then visited the house that could accommodate five residents. At the time of their visit, there was one full-time resident and one respite resident in the centre. Two other residents had already gone to their family homes for the weekend. One resident was watching the television and welcomed the inspector. The other resident had been prepared for the inspector's arrival and met with them briefly in their bedroom. This resident spoke about recent activities and appointments, their interests, book collection, relatives and people they knew. Following this conversation, this resident began to display unsettled behaviours possibly due to the presence of someone they didn't know well in their home. Staff identified this and were observed supporting the resident with this challenge. The inspector left the house shortly afterwards in case their presence was contributing to the resident's distress. While in this house it was noted that maintenance and repair were required in a number of areas. These will be outlined in the 'Quality and safety' section of this report.

Finally the inspector, spent time in the house registered to accommodate six residents. There were four full-time residents in the house and each spent time with the inspector. Two residents did not communicate verbally with the inspector. They appeared at ease in the house and with the support provided by the staff team who clearly knew them well. Staff supported the inspector to understand what the residents were communicating at times and also spoke about what they enjoyed doing while in the house and where they liked to spend their time. Observations indicated that warm relationships had been developed between the staff present and the residents.

One resident gave a tour of the house and another spoke in great detail about their hopes and plans for the renovation of this house. Residents in this house also spoke with the inspector about their interests, recent outings and the staff team. They expressed that they were happy to be getting out more. They appeared to be happy with the supports provided to them and while open about the shortcomings of the house, were happy living there and looked forward to the renovations. They were also positive about living with their peers.

It was previously identified in the September 2021 HIQA (Health Information and Quality Authority) inspection of this centre that this house was not suitable to meet the assessed needs of the residents. This was also a finding of this inspection. One

resident advised that they wished for a kitchen and a utility room that were easier for them to use. They also wanted more space in their bedroom. Another resident wished to have access to a bath. Residents spoke with the inspector about what they wished for their new home and had clearly thought a lot about this. Residents who spoke with the inspector were aware of the need to move temporarily to facilitate building works and also had requests and ideas regarding this interim arrangement.

As well as spending time with the residents in the centre and speaking with staff, the inspector also reviewed some documentation. Documents reviewed included the most recent annual review, and the reports written following the two most recent unannounced visits to monitor the safety and quality of care and support provided in the centre. These reports will be discussed further in the 'Capacity and capability' section of this report. Resident and staff meeting minutes and records of some staff supervision meetings were reviewed. The inspector also looked at a sample of residents' individual files from across the centre. These included residents' personal development plans, healthcare, safeguarding and other support plans.

As this was an announced inspection, resident questionnaires were sent to the provider in advance. 13 questionnaires were completed by either residents or their relatives. These relayed their experiences of spending time in three of the four houses in the centre. Overall the information shared was complimentary about the service provided with respondents providing positive feedback regarding their bedrooms, activities, food and mealtimes, and the staff team. Staff were described as lovely, fantastic, very caring and welcoming. There was a reference to limits placed on visitors to the centre and community based activities in some of the questionnaires. The inspector followed this up with the person in charge who advised that visitors were welcome in all houses in the centre and that residents had resumed community based activities that had been disrupted due to the COVID-19 pandemic. During the inspection, residents also spoke with the inspector about places they had recently been. In one questionnaire, a respondent expressed a wish for the service to go back to what it was like before COVID. They did not elaborate any further so it was not clear what they were referring to specifically in this statement. Another resident expressed their happiness that things were getting back to normal. Any resident who had made a complaint was positive about the way that it had been dealt with. It was noted that one resident named a former staff member as the person they would speak with if they were unhappy about something in the centre. This was raised with the person in charge who committed to ensuring that all residents were aware of the current complaints officer and staff team. An area of concern was reported by one resident who expressed that there were not enough staff at times which worried them. Staffing in the centre will be discussed in the next section of this report. A reference was also made in one questionnaire to a resident suddenly moving to a different house within the centre to receive a respite service. This will also be discussed further later in this report.

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 management arrangements in the centre were under review at the time of this inspection. Staff recruitment challenges meant the designated centre was not adequately resourced to provide all of the services outlined in the statement of purpose. Management systems ensured that all audits and reviews as required by the regulations were being conducted and there was evidence of ongoing efforts to improve the quality of life for residents. Areas that required increased oversight were identified in the course of the inspection and are outlined throughout this report.

The person in charge was appointed in March 2022. They were also the person in charge for another designated centre 50 kilometres away and also fulfilled a senior management role in the organisation. While it was clear that all staff reported ultimately to the person in charge, other elements of the management structure were less clear. For example, where a social care leader was based in a house the other staff working in that house reported to them. However, there were three social care leaders working in one house in the centre. The person in charge advised that a review of the governance arrangements in the designated centre was underway and that in keeping with the regulatory requirements of the role, some staff were completing management qualifications to be eligible to apply for the person in charge position. It was planned to have a new governance structure in place in the coming months.

Regular staff meetings were taking place in all houses in the centre. The inspector reviewed records of these and noted that comprehensive information regarding a number key areas of service provision, the residents and their needs, and the day-to-day running of each house were shared with the staff teams. These meetings were also used to plan the service to be provided to residents in line with their needs and interests. One-to-one staff supervision meetings were also taking place. Although these had not occurred for all staff, this has been identified as an area for improvement by the provider. Review of these meeting records indicated that these meetings were often used by staff to raise their concerns about the quality and safety of the care and support provided to residents.

An annual review and twice per year unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed, as is required by the regulations. Quality improvement plans had been developed following the annual review completed in September 2021 and six-monthly unannounced visits completed in October 2021 and May 2022. There was evidence of progress or follow up regarding a number of identified actions. From a review of these plans, many of the actions outlined appeared to relate to the organisation as a whole rather than to this specific designated centre. There was reference to many

service-wide projects, policies, trainings and initiatives but not necessarily to the day-to-day management of this centre. For example, although it was documented that the provider was planning or had arranged for a variety of additional staff trainings, it was not documented if the staff team's mandatory training was up to date. Similarly, while there was reference to person-centred planning (PCP) training, a PCP framework project and the possible move to an online PCP system, there was little on the quality of the person-centred plans in place for the residents living in this centre. Therefore it was not identified that these required improvement, as was found on this inspection, and as a result no plan was put in place to address these matters.

In their audits, the provider had identified some of the areas requiring improvement that were also identified in the course of this inspection. These included that one house was not fit for purpose and the staff shortages across the designated centre. While there was evidence that significant work had been done to try to address both of these matters, they remained ongoing many months later. Although funding had been secured, there was no timeline in place to renovate one house. This was due to the challenge in identifying a suitable place for residents to live while the required building works were completed. The inability to recruit staff meant that this centre was not sufficiently resourced to provide the service as outlined in their statement of purpose. As a result, some residents were either receiving respite at a reduced level or not at all. In addition, some residents were receiving a respite service in different houses, or in one case a different designated centre, than they used to.

Audits demonstrated learning from other HIQA inspections. It was identified in an inspection of another centre operated by the provider that residents' written agreements with the provider regarding the terms on which the residents lived in the designated centre did not meet the requirements of the regulations. It was referenced in the report written following the unannounced visit in May 2022 that residents' written service agreements required review. This was scheduled for Quarter 3 of 2022.

When reviewing a sample of residents' written agreements it was noted that neither the name of the designated centre nor the details of the service to be provided were included. When reviewing one resident's personal plan it was noted that they had a signed, full-time residential contract with the provider and a tenancy agreement relating to a house in another designated centre. That centre was closed at the time of that inspection due to staff shortages. Despite these agreements, this resident received a respite service every second week from Monday to Friday in this centre. Given the signed agreements in place and the documented wish in this resident's personal plan to access a full-time residential placement, the provider was asked to review the services provided and these agreements with the resident and, where necessary, their representatives.

When reviewing the staffing rosters across the centre it was noted that in one house there was only one staff member working during the day and overnight. On review of the personal plan of a resident who remained in this house during the day it was identified that they were at high risk of falls. It was stated in their associated care plan that they required the support of two staff in the event of a fall. This house

was therefore not staffed appropriately to meet this resident's needs. When reviewing the roster for another house, it was noted that less staff worked in the centre at the weekends than during the week, despite the number of residents remaining the same. A review of documentation identified that a number of staff had highlighted challenges working in this house due to the staffing levels, especially on Saturdays. Staff reported that they were limited to meeting residents' basic care needs only at these times. This had been acknowledged by social care leaders. The person in charge advised the inspector that a review of the residents' assessed needs and the staffing levels in that house was scheduled for Quarter 3 of 2022. This planned review was also reflected in meeting minutes and audit action plans.

The inspector reviewed staff training records available in the centre. These related to 29 staff and did not include the person in charge. 72% of the staff team required training in the management of behaviour that is challenging including de-escalation and intervention techniques. 21% had never received this training and were booked to attend in the coming months. 11 of the 15 staff who required refresher training were also booked to attend. 31% of staff required training in the safe administration of medications with seven staff requiring a refresher and two staff requiring the full training. This was scheduled for some staff later in the month. All current staff had attended trainings in fire safety and in safeguarding residents and the prevention, detection and response to abuse within the timeframes specified in the provider's own policies.

The inspector reviewed behaviour recordings while in one house. It is a requirement of the regulations that specified adverse incidents are notified to the chief inspector within three working days. A number of incidents were recorded in April and May 2022. In one, a resident's behaviour was directed towards a peer, and in another, a resident was reported to be 'shocked' and 'nervous' due to a peer's behaviour. When asked why these incidents had not been notified to HIQA as is required by the regulations, management provided documentation which outlined that a designated officer had visited the centre on 31 May 2022 and had concluded that there was no incident where residents appeared to be negatively impacted. This was not consistent with the inspector's findings.

The inspector reviewed the entries made in the complaints log since the last inspection of this centre. Far more compliments had been recorded than complaints. Any complaints that had been made had been addressed in a timely manner and to the satisfaction of the complainant.

The inspector reviewed the centre's statement of purpose. This is an important document that sets out information about the centre including the types of service and facilities provided, the resident profile, and the governance and staffing arrangements in place. Some revision was required to this document to ensure that the whole time equivalent of the person in charge and staff in each of the houses were accurate. The description of the services provided in each house, including access to day services, also required review to ensure they were accurate. The organisational structure of the designated centre also required revision to ensure that it reflected the roles of the support staff and person in charge. It was stated in

the statement of purpose that the reduced access to respite across the centre was due to the COVID-19 pandemic. It was acknowledged during the inspection that this reduced capacity was due to staffing shortages. The person in charge committed to reviewing the statement of purpose.

## Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application to renew the registration of this centre in line with the requirements outlined in this regulation.

Judgment: Compliant

## Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities

The registered had paid the annual fee outlined in this regulation.

Judgment: Compliant

## Regulation 15: Staffing

The number of staff rostered to work in one house was not appropriate to the assessed needs of a resident. The staffing levels in another house required review to ensure that each day they were appropriate to the number and assessed needs of those residents. Staff personnel files were not reviewed as part of this inspection.

Judgment: Not compliant

## Regulation 16: Training and staff development

72% of the staff team required either initial or refresher training in the management of behaviour that is challenging including de-escalation and intervention techniques. 31% of staff required either initial or refresher training in the safe administration of medications These trainings were booked in the coming months for the majority, but not all, of the staff who required them. All current staff had recently attended training in fire safety and in safeguarding residents and the prevention, detection and response to abuse

Judgment: Substantially compliant

## Regulation 22: Insurance

The provider provided evidence of a current contract of insurance against injury to residents and was asked to submit this to support their application to renew the registration of the centre.

Judgment: Compliant

## Regulation 23: Governance and management

The centre was not sufficiently resourced to deliver the respite services outlined in the statement of purpose. The management structure was not clearly defined in each house in the centre.

The governance and management arrangements in the centre did not ensure that the service provided was consistent and effectively monitored. The remit of the person in charge was large and resulted in reduced capacity for oversight. The annual review and unannounced visits to the centre to monitor the safety and quality of care and support provided often had a broader organisational focus and did not identify many areas that required improvement in the centre. A number of areas of service provision that required increased oversight were identified in the course of this inspection. They included the development and review of residents' support and personal development plans, staffing, notification of incidents, provision of services in line with residents' contracts, staff training, implementation of the provider's safeguarding policy and procedures regarding residents' finances, fire precautions, and protection against infection.

As was found in the last HIQA inspection, the premises in one house were not suitable to meet the needs of the residents living there. Not all staff were receiving supervision in line with the provider's own policy and procedures. This had been identified and a plan was in place to address it.

Judgment: Not compliant

## Regulation 24: Admissions and contract for the provision of services

The written agreements in place did not include all of the required information as set out in this regulation. The service provided to one resident was not consistent

with the service outlined in their written agreement.

Judgment: Not compliant

## Regulation 3: Statement of purpose

The statement of purpose required review to accurately reflect the whole time equivalents of the person in charge and other staff complement, the description of the services provided in each house, the organisational structure of the designated centre, and the reasons that the respite service was being offered at a reduced capacity.

Judgment: Substantially compliant

## Regulation 31: Notification of incidents

Not all adverse incidents that occurred in the centre were notified to the chief inspector, as is required by this regulation.

Judgment: Not compliant

## Regulation 34: Complaints procedure

An effective complaints procedure was in place. A review of the complaints log demonstrated that any complaints made were investigated promptly, measures required for improvement were put in place, and the satisfaction of the complainant was recorded.

Judgment: Compliant

## Quality and safety

A review of documentation and the inspector's interactions and observations indicated that residents enjoyed spending time in this centre. The inspector found that some aspects of the quality and safety of care provided in the centre required improvement. These areas are outlined in the remainder of this report.

The inspector reviewed a sample of the residents' personal plans. Residents' healthcare needs were well met in the centre. Where a healthcare need had been identified a corresponding healthcare plan was in place. There was evidence of appointments with medical practitioners including specialist consultants as required. There was also evidence of input from allied health professionals such as psychologists, physiotherapists, occupational therapists and speech and language therapists. Multidisciplinary reviews of residents' personal plans took place at least annually, with some occurring more frequently.

It was identified that not all support plans, including some healthcare plans, had been reviewed in the previous 12 months, as is required by the regulations. Due to one resident's sensory disability, it had been recommended that that any environment they accessed be audited in the event of any changes and that all staff to receive specific training. Previously this resident accessed services in another designated centre where these recommendations had been implemented. However, this had not happened in this centre despite them regularly staying there.

Residents' personal plans also included plans to maximise their personal development in accordance with their wishes, as is required by the regulations. During the pandemic, the provider had moved to a wellbeing plan for residents to reflect the limits on community based activities due to national restrictions and also to reflect the supports to be provided to residents during this extraordinary time. Of the sample of wellbeing and person-centred plans reviewed, there was often no documented review or progress of residents' goals. One resident's plan, dated April 2021, stated that they wished to receive a weekly Monday to Friday residential service. There was no evidence that this goal had been reviewed and at the time of this inspection, they received a Monday to Friday service every second week, despite the fact that they had a signed, full-time residential service agreement with the provider. It was a goal for another resident to go to the cinema. Although this goal was in place since September 2021, and according to documentation was to be reviewed weekly, there was no noted progress in achieving this eight months later. It was also noted that a number of residents' goals were repeatedly carried over from previous years.

The person in charge advised that a review was planned regarding the suitability of this designated centre to meet one resident's needs. A recent multidisciplinary review had taken place and a number of actions were developed to support this planned review. Assessments regarding the suitability of the environment and the impact of this resident's behaviour on their peers had also been scheduled.

Six residents living in the centre had safeguarding plans in place. These had been recently reviewed. As outlined in the previous section of this report, it had been assessed that none of the incidents regarding one resident's behaviour had had any negative impact on their peers. Despite this, three of this resident's peers had current safeguarding plans. It was documented that there had been liaison with the Safeguarding and Protection Teams who advised to monitor the situation and report any adverse incidents should they arise. Incidents reviewed by the inspector referenced negative impacts experienced by peers. These incidents had not been reported to the Safeguarding and Protection Teams or notified to HIQA, as is

required by the provider's own safeguarding policy.

There were some restrictive practices in use in the centre. The provider had a group in place to review these practices. There was evidence that this group met regularly. The person in charge was a member of the group. They advised the inspector that a restrictive practice involving an item of clothing was being considered for one resident but had not yet been approved. When the inspector met with this resident they were wearing this item. When asked about this, the person in charge advised that it would be restrictive if the item was worn under other clothing. Given that staff advised the inspector that the resident could independently remove this item of clothing whether it was under or over other clothing, clarity was required as to why this was considered a restriction in one circumstance and not the other.

The person in charge advised that residents had returned to community based activities and that a number of activities, such as the local Special Olympics group, had restarted in recent weeks. Not all full-time residents of this centre had returned to their day services. It was explained that some residents had gone for parts of the day and had expressed an unease about returning. Instead it was being explored if they would prefer to participate in activities using the designated centre as their base, as has been the case since the outset of the COVID-19 pandemic. The person in charge explained that this would be discussed with residents as part of the person-centred planning processes implemented in the centre.

Residents' meetings were held weekly in the centre. The focus of these meetings differed based on the service provided in each house. Where only a respite service was provided, meetings focused on meal and activity planning for the duration of the stay. Where a long-term residential service was provided meetings were wider in scope and discussed topics such as the upcoming HIQA inspection, future plans and upcoming changes in the house. Some of the minutes involved the use of photographs which made the information more accessible to the residents. Information regarding advocacy services were on display in each house in the centre.

All four houses were decorated in a homely manner. In some bedrooms residents had chosen to display photographs, art works, books and other belongings that they liked or were important to them. Staff in one house spoke with the inspector about how they changed the photographs in one bedroom every week to match the resident who would be staying there. As outlined in the opening section of this report maintenance and repair were required in parts of all four houses.

As had been identified previously in the September 2021 HIQA inspection, and acknowledged by the provider, one house was not suitable to meet residents' assessed needs due to its design, layout and accessibility. In the compliance plan submitted following the September 2021 HIQA inspection of the centre, the provider outlined that some funding had been secured to fully refurbish this house. In order for this work to progress, temporary alternative accommodation was required for the residents. At that time, this was expected to be secured by March 2022. At the time of this inspection, in June 2022, work was ongoing to source this accommodation. As a result, there had been no change to the premises in that time.

As outlined in the opening section of this report, some residents expressed the reasons the premises were unsuitable to meet their needs. This was also observed by the inspector.

Identified issues in the other three houses included walls that required repainting, broken mirrors that needed to be replaced or removed, torn upholstery on furniture, damaged tiles, and broken doorframes on sliding doors. Damaged surfaces were observed on countertops, bedroom furniture and kitchen units. It was also noted that storage was an issue in one house where it was observed that the vacuum cleaner was stored in the downstairs bathroom. When in the garden area of one house it was noted that the path to the assembly point was obstructed by overgrown plants. This was of particular concern as some of the residents in this house had assessed mobility needs and required staff support, including with the use of mobility aids, when outside.

The premises had fire safety systems including a fire alarm, emergency lighting and fire extinguishers while measures had also been taken relating to fire containment in order to prevent the spread of fire and smoke. Such fire systems were being serviced regularly by external contractors to ensure they were in proper working order. As outlined in the opening section of this report, the use of objects to keep fire doors open was noted repeatedly in one house. When reviewing the Personal Emergency Evacuation Plans (PEEPs) in place for residents it was noted that these were not always consistent with the information contained in residents' mobility support plans and in one instance had not been completed in full.

The inspector reviewed some of the systems in place regarding the prevention and control of healthcare associated infections, including COVID-19. Outbreak management plans had been developed for each of the four houses. These detailed information relating to each resident and possible challenges in supporting them during an outbreak. Names and contact details of relief staff were also included. Some review was required to the plans. Guidance in these documents repeatedly referenced the use of surgical masks. This was not consistent with public health guidance which recommended the use of respirator masks in the event of confirmed cases of COVID-19. It was also noted that all of these documents referenced and assigned responsibilities to the former person in charge.

Infection prevention and control (IPC) reviews were completed weekly in each house. Daily cleaning checklists were also in place. In addition the person in charge also completed audits regarding IPC practices such as the recording of staff and residents' temperatures and cleaning. Training records indicated that the majority of staff had completed IPC training. The two outstanding staff had been asked to complete this as a matter of urgency. 18 staff (62% of the staff team) required refresher hand hygiene training and records indicated that one staff member had never completed this training.

The centre was observed to be clean on the day of inspection. However, as outlined previously, some damaged surfaces were observed throughout the centre. As a result it would not be possible to effectively clean these surfaces. When in one bedroom, it was noted that medical equipment used by resident was not stored in a

clean place when not in use. This posed a contamination risk. The inspector reviewed the laundry area in one of the houses. A system was in place to keep each resident's laundry separate. Two residents who stayed in this house were involved in managing their own laundry while another preferred to bring their laundry home to be washed.

The provider had prepared a guide with information regarding the designated centre for the residents, as is required by the regulations. The same guide was used for all four houses and for those who accessed either a full-time or a respite service. This posed challenges as no differentiation was made between the services provided to residential and respite groups and statements such as 'this is your home' were not reflective of respite residents' experiences. All other required areas, as outlined in the regulations, were addressed in this guide.

## Regulation 17: Premises

As was found on the last inspection, one house was not designed and laid out to meet the assessed needs of residents. A renovation to this house was proposed but there was no definitive plan in place for works to commence at the time of this inspection. Areas requiring maintenance were identified in all four houses in the centre. It was also noted that there was not sufficient storage in all of the houses.

Judgment: Not compliant

## Regulation 20: Information for residents

The guide prepared in respect of the designated centre required review to ensure that it accurately reflected the two models of service provided in the centre.

Judgment: Substantially compliant

## Regulation 27: Protection against infection

Procedures had been adopted to ensure residents were protected from healthcare associated infections including COVID-19. The outbreak management plans in place required review to ensure they were consistent with public health guidance and reflected the current management team. Although the centre was observed to be clean, there were some damaged surfaces. As a result it would not be possible to effectively clean these surfaces. Improvement was required regarding the storage of personal medical equipment. While the majority of staff had recently completed IPC

training, 62% of the staff team required refresher training in hand hygiene.

Judgment: Substantially compliant

## Regulation 28: Fire precautions

Fire safety systems in place in this designated centre included a fire alarm, emergency lighting and fire fighting equipment. These systems were serviced and monitored. Training records reviewed indicated that all staff had received fire safety training. Staff practices regarding keeping doors open prevented some doors from closing if required to act as a containment measure in the event of a fire. Residents' PEEPs required review to ensure they were completed in full and were consistent with residents' assessed mobility needs. The escape route in one garden required maintenance to ensure that residents would be able to use it to access the identified assembly point.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

There was guidance for staff regarding the support needs of residents, however not all documents in residents' personal plans had been reviewed in the last 12 months, as is required by the regulations. Although personal development goals had been identified for residents, there was no plan in place or person responsible to support residents in achieving these goals. At the time of inspection there had been no review or progress noted for the majority of residents' goals. Goals were repeatedly carried over from previous years. Recommendations made regarding one resident's visual impairment had not been implemented despite them regularly staying in this centre.

Judgment: Not compliant

## Regulation 6: Health care

Residents' healthcare needs were well met in the centre. Residents had access to medical practitioners and allied health professionals as required.

Judgment: Compliant

## Regulation 7: Positive behavioural support

It was documented in one resident's personal plan that the behaviour support plan in place was not effective. However, no revised or alternative guidance was available to the staff team to support this resident. Clarity was also required regarding whether an intervention was to be considered restrictive or not.

Judgment: Substantially compliant

## Regulation 8: Protection

Although safeguarding plans had been developed, adverse incidents had not been reported to the chief inspector or the Safeguarding and Protection team in line with the provider's own policy. Not all of the provider's procedures to safeguard residents' money were implemented in the centre.

Judgment: Substantially compliant

## Regulation 9: Residents' rights

Residents were encouraged and supported to exercise choice and control in their daily lives. Weekly resident meetings were held in each house in the centre. Residents' feedback and input was sought regarding the proposed renovation to one house.

Judgment: Compliant

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

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Registration Regulation 5: Application for registration or renewal of registration | Compliant |
| Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities | Compliant |
| Regulation 15: Staffing | Not compliant |
| Regulation 16: Training and staff development | Substantially compliant |
| Regulation 22: Insurance | Compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 24: Admissions and contract for the provision of services | Not compliant |
| Regulation 3: Statement of purpose | Substantially compliant |
| Regulation 31: Notification of incidents | Not compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Not compliant |
| Regulation 20: Information for residents | Substantially compliant |
| Regulation 27: Protection against infection | Substantially 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 | Substantially compliant |
| Regulation 8: Protection | Substantially compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Bantry Residential OSV-0002105

## Inspection ID: MON-0028040

## Date of inspection: 03/06/2022

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

This document is divided into two sections:

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

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

A finding of:

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

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

## Section 1

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

**Compliance plan provider's response:**

| **Regulation Heading** | **Judgment** |
|---|---|
| Regulation 15: Staffing | Not Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>• Due to the changing need of the resident highlighted in the report, the staffing in this house has been changed to ensure the staffing in line with all residents needs in this house. This individual is also exploring more appropriate residential placements in consultation with their family and circle of support.<br>• An assessment of need is underway for the resident in the second identified house, in order to ensure the staffing levels are appropriate to the needs of the residents. | |
| Regulation 16: Training and staff development | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 16: Training and staff development:<br>Since the inspection sessions of training in the management of behavior that is challenging has taken place and a further two dates are scheduled, all gaps in medication training have been resolved.<br><br>A robust organization wide system of training management is currently under development, to ensure CoAction's compliance with regulation 16. | |

| | |
|---|---|
| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• CoAction are reviewing the current Statement of Purpose to reflect ongoing staffing crisis and the centres current staffing capacity. While we continue all endeavors to recruit.
• A clearly defined management structure is currently being developed and under review for the designated centre and each individual residence, in conjunction with the staff team.
• Senior internal staff are currently undergoing their management training in order to be sufficiently qualified to undertake the PIC role. These staff member sole remit will be the role of PIC for the designated centre.
• Coaction endeavors to complete high quality 6 monthlies and annual reviews, and to ensure a comprehensive focus on local issues the Quality Risk and Development Manager is currently developing audit tools for each of the local services that will underpin and enhance the current reports.
• In relation to premises funding has been secured and CoAction as an organization are currently in negotiation with the HSE regarding an identified suitable alternative premises. These negotiation if successful will expedite the renovations.
• A plan in relation to the supervision of staff has been enacted and a schedule of supervision is in place.

| | |
|---|---|
| Regulation 24: Admissions and contract for the provision of services | Not Compliant |

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
• Contracts of Care have been identified at an organizational level as a need for improved. Contracts of care will be reviewed to ensure all appropriate information is present.
• Individual residents contract that are not accurate are being review locally to ensure they are representative of the service provided.

| | |
|---|---|
| Regulation 3: Statement of purpose | Substantially Compliant |

| |
|---|
| Outline how you are going to come into compliance with Regulation 3: Statement of purpose:<br>• Statements of Purpose have been identified at an organizational level as requiring improvement. All Statement of Purpose's will be reviewed to ensure all appropriate information is present and it is the current reflection of the designated service. |

| | |
|---|---|
| Regulation 31: Notification of incidents | Not Compliant |
| Outline how you are going to come into compliance with Regulation 31: Notification of incidents:<br>• In line with the regulations, CoAction have changed their reporting system. If at any time a member of the designated centre consult or deems it appropriate to consult with a member of the social work department either internally or externally to discuss if an incident is appropriate referral, this will trigger an automatic notification HIQA regardless of outcome from the consultation. | |

| | |
|---|---|
| Regulation 17: Premises | Not Compliant |
| Outline how you are going to come into compliance with Regulation 17: Premises:<br>• In relation to premises of one individual house funding has been secured and CoAction as an organization are currently in negotiation with the HSE regarding an identified suitable alternative premises. These negotiation if successful will expedite the renovations.<br>• A maintenance man has been appointment and a referral system for the designated centre and for immediate works are in place. Arising out of this a maintenance plan is currently being devised and actions are being prioritized.<br>Alternative storage units are currently being identified. | |

| | |
|---|---|
| Regulation 20: Information for residents | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 20: Information for residents:<br>Resident's guides have been identified at an organizational level as requiring | |

| |
|---|
| improvement. All Residents Guide will be reviewed to ensure all appropriate information is present and it is the current reflection of the designated service |

| | |
|---|---|
| Regulation 27: Protection against infection | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• A maintenance man has been appointment and a referral system for the designated centre and for immediate works are in place. Arising out of this a maintenance plan is currently being devised and actions are being prioritized.
• Alternative storage units are currently being sourced.
• A robust organization wide system of training management is currently under development, to ensure CoAction's compliance with regulation 16.
• The outbreak management plans have been reviewed.

| | |
|---|---|
| Regulation 28: Fire precautions | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• All door jams have been removed from the designated centre.
• Maintenance was work was completed following the inspection.
• CoAction are currently in the process of hiring a fire engineer to review all Fire Sytems and designated centre including protocols, policies and systems.

| | |
|---|---|
| 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:
• CoAction is currently undertaking a Person Centered Planning review to establish a baseline of plans in the centre. In order to ensure compliance with regulation, work is underway to ensure that all residents, should they so wish, have a current person-centered plan. Completion date: 30/11/2022
• The Person in Charge and the Quality, Risk and Development Manager will meet with

the Social Care Leader team on 29th August to discuss the Person Centred Plan, the importance of quality within the plans and the necessity to evidence the progression of identified goals and the regular timely review of plans.
• In relation to the individual noted in the inspection report with outstanding actions from their care plan. CoAction have linked with the appropriate clinicians to action the points and are awaiting response.

Along with the actions identified above, the following is also underway within the organization.

• Person Centre planning training in conjunction with Assisted Decision Making training is being rolled out to the designated centre.
• Management and Senior staff have received person centred planning leadership training.
• A review of the suite of documentation and it's effective is currently underway.
• The Quality Risk and Development Manager is currently developing audit tools for each of the local services that will underpin and enhance the current plans.

| | |
|---|---|
| Regulation 7: Positive behavioural support | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• A review of the resident's behavior support plan will take place to ensure it effectiveness. This will be discussed at the local Multi-disciplinary team meeting on 8th September.
• The application regarding the proposed restrictive practice will be sent to the organization's Restrictive practice committee for review, if following the continued input from the psychologist, the proposed restriction is deemed appropriate. The restrictive practice committee will deem the practice appropriate or restrictive. The next restrictive practice committee is the 26th of September.

| | |
|---|---|
| Regulation 8: Protection | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 8: Protection:
• In line with regulations, CoAction have changed their reporting system. If at any time a member of the designated centre consult or deems it appropriate to consult with a member of the social work department either internally or externally to discuss if an incident is appropriate referral, this will trigger an automatic notification HIQA regardless

of outcome from the consultation.
• With immediate effect following the inspection. All staff in the designated centre were refreshed on the importance of the finance procedures. All safes remain locked.

## 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 | 30/09/2022 |
| Regulation 16(1)(a) | The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme. | Substantially Compliant | Yellow | 31/10/2022 |
| Regulation 17(1)(a) | The registered provider shall ensure the premises of the designated centre | Not Compliant | Orange | 31/03/2023 |

| | | | | |
|---|---|---|---|---|
| | are designed and laid out to meet the aims and objectives of the service and the number and needs of residents. | | | |
| Regulation 17(1)(b) | The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally. | Not Compliant | Orange | 31/03/2023 |
| Regulation 17(6) | The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all. | Not Compliant | Orange | 31/03/2023 |
| Regulation 20(2)(a) | The guide prepared under paragraph (1) shall include a summary of the services and facilities provided. | Substantially Compliant | Yellow | 31/12/2022 |
| Regulation 23(1)(a) | The registered provider shall ensure that the | Not Compliant | Orange | 30/09/2022 |

| | | | | |
|---|---|---|---|---|
| | designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose. | | | |
| Regulation 23(1)(b) | The registered provider shall ensure that there is a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision. | Not Compliant | Orange | 30/09/2022 |
| Regulation 23(1)(c) | The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. | Not Compliant | Orange | 30/09/2022 |
| Regulation 23(3)(a) | The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to | Substantially Compliant | Yellow | 19/08/2022 |

| | | | | |
|---|---|---|---|---|
| | exercise their personal and professional responsibility for the quality and safety of the services that they are delivering. | | | |
| Regulation 24(4)(a) | The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged. | Not Compliant | Orange | 31/12/2022 |
| Regulation 27 | The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority. | Substantially Compliant | Yellow | 30/09/2022 |
| Regulation 28(2)(b)(ii) | The registered provider shall make adequate arrangements for reviewing fire precautions. | Substantially Compliant | Yellow | 30/11/2022 |

| | | | | |
|---|---|---|---|---|
| Regulation 28(2)(c) | The registered provider shall provide adequate means of escape, including emergency lighting. | Substantially Compliant | Yellow | 19/08/2022 |
| Regulation 28(3)(a) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Substantially Compliant | Yellow | 19/08/2022 |
| Regulation 03(1) | The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1. | Substantially Compliant | Yellow | 30/09/2022 |
| 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 | 19/08/2022 |
| Regulation 05(3) | The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1). | Substantially Compliant | Yellow | 30/09/2022 |
| Regulation 05(4)(b) | The person in charge shall, no | Not Compliant | Orange | 30/09/2022 |

| | | | | |
|---|---|---|---|---|
| | later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes. | | | |
| Regulation 05(6)(c) | The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan. | Not Compliant | Orange | 30/11/2022 |
| 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 | 30/12/2022 |
| Regulation 07(1) | The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to | Substantially Compliant | Yellow | 19/09/2022 |

| | | | | |
|---|---|---|---|---|
| | respond to 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. | Substantially Compliant | Yellow | 26/09/2022 |
| Regulation 08(2) | The registered provider shall protect residents from all forms of abuse. | Substantially Compliant | Yellow | 19/08/2022 |
| 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. | Substantially Compliant | Yellow | 19/08/2022 |