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

Issued by the Chief Inspector

Name of designated centre:	Abode Doorway to Life CLG
Name of provider:	Abode Doorway to Life CLG
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	29 November 2022
Centre ID:	OSV-0002411
Fieldwork ID:	MON-0038067

About the designated centre

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

The designated centre provides residential and respite services for up to 10 adults with physical and sensory disabilities on the outskirts of Cork City. The designated centre is a purpose built building, which comprises of residential units and communal areas for residents. The service operates 24 hours a day, 7 days a week all year round. Staff sleep over in the accommodation provided and are on call for emergencies. The staff team comprises of social care, care and nursing staff.

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
Tuesday 29 November 2022	08:55hrs to 20:35hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

This inspection was completed as a follow-up to an inspection, completed on behalf of the Chief Inspector of Social Services, of the designated centre in March 2022. At that time there were a number of not compliant judgments with the regulations. As a result, the provider entered regulatory escalation processes. Findings of this inspection indicated significant improvements in compliance levels with a number of key regulations which indicated that a safer, higher standard of service was being provided to residents.

The designated centre was located in a purpose-built facility in a suburb of Cork city. The centre was registered to provide a residential service for a maximum of 10 people with physical and sensory disabilities. Parts of the building were not included in the designated centre. Services provided in these areas included a day service, a training service, and other accommodation where people lived as part of a tenancy arrangement. Overnight accommodation was provided over two floors in the split-level building. This design ensured that those on the first floor could access the outdoors using external doors. Each resident had their own bedroom with an en-suite bathroom. Two accommodation units had a studio apartment layout which included an accessible kitchen, dining and living area, a bedroom, and a bathroom. Management advised that residents were encouraged to personalise their rooms and had recently begun to put more artworks on display. Since the last inspection of the centre, two residents had moved bedrooms. These moves were initiated by the residents and supported by management. As a result one resident now had access to fixed equipment to support them with transfers, and another had a bedroom with an external door. Records reviewed on the day outlined that residents were appreciative that these requests had been accommodated with one resident reporting that as a result of the move they now felt safer in their home. Following their move, one resident had redecorated their room and was very happy with how it now looked. Work had been completed in the centre to make some bedrooms more accessible to residents. Fobs had been installed on two external bedroom doors so that the residents staying in them could access the outside areas independently.

There were communal areas on both floors of the centre. On the ground floor there was a dining room (fitted with a large television) and a studio apartment that had been repurposed as a residents' lounge. The availability of the residents' lounge had been introduced since the last inspection in March 2022. As this was a new addition to the floor plan of the centre, the provider was asked to submit an application to vary the registration conditions of the centre. This area comprised a bathroom, a kitchen, dining and living area, and another smaller room. It was well-furnished and a television had been installed. It was explained to the inspector that at times the smaller room was used by visiting health and social care professionals if they wished to meet with residents in a private setting, other than their bedrooms. However, it was available for residents' use the majority of the time. The inspector was told that some residents chose to spend time with visitors in this area, while others used it to

watch television, or enjoy a takeaway in smaller groups. One resident chose to speak with the inspector there. The kitchen was fully accessible to residents and was equipped with cooking and baking facilities and appliances. As the main kitchen in the centre was a commercial kitchen, not accessible to residents, the availability of this area provided residents with free, independent access to cooking facilities.

On the first floor of the building there was a common area with tables, various seats, and a computer for general use. Tea and coffee making facilities, and snacks, were also available. A large screen and a ceiling-mounted projector had been installed in recent weeks and it was planned to connect it to the electricity supply in the coming days. The inspector was told that residents planned to watch films in this area. Improvements to the outdoor areas were also observed since the last inspection. Additional outdoor furniture was in place, existing furniture had been repainted, and some planting had been completed. Residents were positive about these outdoor spaces and the inspector saw photographs of them enjoying meals outside during warmer weather.

There were two types of supported accommodation service provided to residents in the designated centre. There was a long-term residential service available to seven residents, and a respite service available to up to three residents at any one time. Since the last inspection of this centre, a person who had previously accessed respite in the designated centre had become a long-term resident. Due to the COVID-19 pandemic, the majority of people who had accessed respite in the centre had chosen not to stay in the previous two years. Management advised that they were focused on resuming the respite service and hoped to provide this service throughout the year. The inspector was informed that revisions had been made to the application and assessment templates and these were to be proposed to the board for approval in the coming weeks. As will be outlined in the 'Quality and safety' section of this report, improvements were required in the assessments and personal planning completed with, and for, those accessing respite in the centre.

This was an unannounced inspection. As this inspection took place during the COVID-19 pandemic, enhanced infection prevention and control procedures were in place. The inspector and staff adhered to these throughout the inspection. On their arrival the inspector was greeted by the person in charge and very shortly afterwards met other members of the management team. On the day of this inspection, there were seven long-term residents and one person accessing respite in the centre. The inspector spoke with a number of staff and two residents. They also spent time in the dining room while other residents were present. All residents who were in the centre during the inspection were informed of the inspector's presence and were invited to speak with them if they wished.

An inspector met with one resident in their bedroom. This had been personalised and reflected the interests and personality of the resident living there. It was furnished with equipment to support the resident's independence in their day-to-day, and preferred, activities such as reading and listening to audio books. The inspector spoke with the resident about some of the art and photographs they had on display. The resident was curious about the role of HIQA (Health Information and Quality Authority) and the regulations. They initially had thought the inspector was

there to discuss a specific matter but was then happy to speak about their experiences of living in the centre. This resident was positive about the support they received from staff, the peers they lived with, and the facilities available. They emphasised that they enjoyed going out and mentioned the importance of wheelchair-accessible venues. The resident spoke with the inspector about their goals and their key worker. Overall, this resident appeared happy living in the centre and with the services provided to them.

The inspector met with a second resident in the residents' lounge. Prior to the meeting, they had been watching television there. They told the inspector they enjoyed spending time in that area. This resident spoke about their job and the importance of their independence to them. They told the inspector that they enjoyed participating in activities outside the centre and referenced a recent meal in a local hotel. Although acknowledging that they now go out most weekends, they expressed that they would like to go out more. This resident spoke with the inspector about barbeques held in the centre over the summer and the option now available to eat outside. They were positive about their peers and referenced a group of male residents who meet up regularly. This resident told the inspector that they liked watching films and looked forward to the projector being set up upstairs. They also spoke about their key worker and the supports that they provide to them. This resident also appeared content with the service provided and, aside from additional outings, did not express anything that they would like changed or improved.

On the day of the inspection a number of residents were involved in activities outside the centre. The inspector observed and overheard interactions between staff and residents as they returned to, and left, the centre throughout the day. All interactions were warm and respectful. When walking around the designated centre, the inspector saw residents coming and going, and participating in their day-to-day activities. All residents appeared at ease in the centre and it seemed very much like their home.

As this inspection was not announced, feedback questionnaires for residents and their representatives had not been sent in advance of the inspection. The inspector reviewed the feedback gathered from eight residents as part of the provider's annual review process completed in August 2022. Overall, the feedback received was very positive. Residents reported that they were very happy and comfortable living in the centre. One resident reported that they now had a lot more freedom and had gained independence living in the designated centre. Members of the staff team were described as lovely, kind, generous, and helpful. One resident reported that there was a lovely atmosphere in the centre. Residents outlined some of the activities they enjoyed. As was reported to the inspector when they met with residents, three respondents expressed that they would like to go out more. Where residents had raised issues, they were satisfied with how the provider had responded. Residents had also put forward suggestions as to how the service could be improved. These included making changes to the menu and organising a sports day. This was a change from the findings of the previous inspection when it was reported that residents were reluctant to raise matters that they would like addressed. There was evidence that actions had been put in place regarding

residents' suggestions.

As well as spending time with the residents in the centre and speaking with staff, the inspector also reviewed some documentation. It was evident that the majority of actions outlined in the compliance plan submitted following the last inspection had been fully completed. The one outstanding action had been progressed and was expected to be completed in the near future. Documents reviewed included the most recent annual review, and the report written following the most recent unannounced visit 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. Staff training was reviewed and while staff had completed most of the training required, some was outstanding. Additional oversight of the training matrix was required, as were improvements in some of the documentation regarding fire safety. The centre's complaints log was reviewed, as were planned and actual staff rosters. Significant improvements were required in medication management practices in the centre. The inspector looked at a sample of risk assessments and although recently reviewed, further revision was necessary to ensure that the risk assessments were accurate and reflective of the hazards present in the centre. The inspector also looked at a sample of residents' individual assessments and plans. These included residents' personal development plans, healthcare and other support plans. While it was clear that a lot of work had recently been done in this area, improvement was required regarding the plans, especially those developed for those accessing respite services in the centre. These and other findings will be outlined in more detail in the remainder of 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

Overall, good management practices were seen. The provider had adequately resourced and staffed the service, and it collected information in order to improve the quality of life of residents. Management systems ensured that all audits and reviews as required by the regulations were being conducted. Additional auditing systems had also been introduced. At the time of this inspection, a number of newly introduced systems and governance arrangements were at a relatively early stage of implementation. As you would expect, these processes were still being reviewed and refined. Key areas requiring improvement at the time of this inspection included the oversight and implementation of the provider's medication policy, the regular review of residents' personal plans ensuring that all required supports were available, and the assessment and development of personal plans for those accessing respite in the centre.

In keeping with the compliance plan submitted following the last inspection, governance and management arrangements in the designated centre had been strengthened. There were now clearly-defined management structures in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. There was no appointed person in charge at the time of the last two inspections of this centre. A person in charge, working on a full-time basis, was appointed in May 2022. This role was fully supernumerary. Social care workers, care and nursing staff all reported to the person in charge. They reported to the acting chief executive, who reported to the board. The person in charge and other members of the management team were based in the building that housed the designated centre. Management presence in the centre provided all staff with opportunities for management supervision and support.

Staff meetings were taking place regularly in the centre as were one-to-one supervision meetings. Further meetings were scheduled for the remainder of the year. The inspector reviewed a sample of these meeting minutes. Records indicated that a number of key areas were standard agenda items at staff meetings. These included adverse incidents, safeguarding, policies and procedures, infection prevention and control (IPC), residents' plans and personal goals, and the respite service provided in the centre. New information and initiatives were also shared, such as the requirement for all staff to complete human rights training.

The person in charge and another member of the management team had completed related training and were now fulfilling the role of designated officers in the centre. This role was also vacant at the time of the March 2022 inspection, despite being required by the provider's own safeguarding policy. At the time of the last inspection, the complaints officer worked limited hours in the centre each week. It was found at that time that some residents felt that they could not report a complaint for the majority of the week and the complaints officer had very limited time to fulfil the responsibilities of this role as well as their other assigned duties. While this person still fulfilled that role a second person had also been identified to support the management of complaints. The photographs of both staff and information regarding the complaints procedure were available throughout the centre. Management had also spoken repeatedly with residents to advise them that any member of staff could receive a complaint. The two residents who spoke with the inspector advised that if there was anything they were not happy with that they would speak with their key worker or the person in charge.

The inspector reviewed the complaints log. One complaint was recorded in the complaints log since the last inspection of the centre. There was evidence that this had been responded to promptly, follow-up actions initiated, and the complainant kept informed of progress. It was documented that the complaint was closed and the complainant was satisfied with the outcome although the matter was yet to be addressed. Management explained that the complainant had expressed their satisfaction with the plan in place. Management advised that they would revise the complaints log record to ensure that the complaint remained open until the matter was resolved.

The provider had completed an annual review and six-monthly unannounced visits to review the quality and safety of care provided in the centre, as required by the regulations. The annual review was completed in August 2022 and involved consultation with residents and their representatives, as is required by the regulations. This feedback was referenced in the opening section of this report. An unannounced visit had taken place in May 2022, with another planned for the same day as this inspection. When the inspector arrived, the auditor decided to postpone their visit. Where identified, there was evidence that actions to address areas requiring improvement were being progressed or had been completed.

In the September 2021 inspection of this centre, it was identified that the reports written following the unannounced visits were not comprehensive, did not review many aspects of the care and support specified in the regulations, and despite the findings of that inspection, had not identified any areas where improvement was required. In the compliance plan submitted following that inspection, to address this finding, the provider had committed to using a different template more aligned to the regulations. However it was found in March 2022 that the provider had not implemented this plan. In contrast, the most recent report written in May 2022 covered a breadth of regulations and identified areas requiring improvement to meet the requirements of the regulations. It was also noted that management and staff were now also completing a number of other audits and checks on a regular basis in the centre. Areas monitored included medication management, adverse incidents, restrictive practices, fire safety, cleaning, and practices associated with infection prevention and control (IPC). While some of these audits required improvement, these systems supported the provider to effectively monitor the safety and quality of care and support provided in the designated centre.

In advance of this inspection, the inspector reviewed notifications that had been submitted regarding this designated centre to the Chief Inspector. The records of any adverse incidents that had occurred were also reviewed by the inspector while in the centre. It was identified that all adverse incidents, identified as required in the regulations, had been reported to the Chief Inspector. The person in charge was regularly auditing these incidents to identify trends and the learning from these reviews was discussed at staff meetings.

At the time of this inspection the provider was undertaking a review of the written service agreements for both full-time residents and those who accessed respite in the designated centre. Some of the terms in which residents lived in the centre had been revised to be more in keeping with a human rights approach to the provision of social care and to reflect residents' independence in many areas of their lives.

Previously the provider was assessed as being not compliant with the regulation regarding staffing. A review of the staffing roster had been completed since then. There was now a minimum of two staff in the centre at any time, with three staff most often rostered in the mornings and evenings to meet the needs of the residents in the centre at those times. There were two night staff rostered, with both completing sleepover shifts. There were no nursing staff rostered to work in the centre at weekends. Management advised that this staffing level was consistent with residents' assessed level of nursing care needs. Planned and actual staff rosters

were available in the centre. From a review of a sample selection, the inspector assessed that staffing was routinely provided in the centre in line with the staffing levels outlined in the planned roster and statement of purpose. There had been a number of staff changes in the centre in the last six months, with five new staff employed to work in the centre. There were no vacancies in the staff team at the time of inspection, with a relief staff member recently recruited.

The inspector also reviewed staff training records regarding areas identified as mandatory in the regulations. It was identified that over half of the staff team required training in the management of behaviour that is challenging including de-escalation and intervention techniques, with many having never received this training. It was also identified that the training matrix in place did not reference all training recently completed. This information was sourced during the inspection to ensure the inspector was presented with all current information regarding staff training.

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. This document met the majority of the requirements of the regulations. Some revision was required to ensure that the staffing whole-time equivalents (WTE) and minimum staffing levels were accurate throughout the document, to further clarify the admission criteria, and to remove outdated registration conditions that had been included in error.

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

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

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was employed on a full-time basis and had the skills, qualifications and experience necessary to manage the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The number and skill-mix of staff was appropriate to the number and assessed

needs of the residents, the statement of purpose and the size and layout of the designated centre. Staff personnel files were not reviewed as part of this inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Half of the staff team required required training in the management of behaviour that is challenging including de-escalation and intervention techniques. The team had recently completed the other trainings identified as mandatory in the regulations.

Judgment: Substantially compliant

Regulation 21: Records

This regulation was not inspected in full. It was identified that records of nursing care provided to one resident while staying in the centre were not available.

Judgment: Substantially compliant

Regulation 23: Governance and management

The management structure in place ensured clear lines of authority and accountability. The provider had sufficiently resourced the centre. An annual review and unannounced visits to monitor the safety and quality of care and support provided in the centre had been completed. There was evidence that where issues had been identified, actions were completed to address these matters. Management were very responsive to issues identified. Management presence in the centre provided all staff with opportunities for management supervision and support. Staff meetings and one-to-one meetings were regularly taking place which provided staff with opportunities to raise any concerns they may have. While there was evidence of effective management systems in place to ensure that the service provided was safe, consistent and appropriate to residents' needs, findings of this inspection indicated that improvements were required in the area of individualised assessment and personal planning, and to ensure effective oversight and implementation of the provider’s policies and procedures regarding medication management. Improved oversight was also required regarding staff training and the implementation of infection prevention and control (IPC) measures in the centre.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

A review of residents' written service agreements were underway. Not all residents who recently accessed respite had an up-to-date service agreement that reflected changes made to the terms regarding residents staying in the centre.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose required review to ensure that the staffing whole-time equivalents (WTE) and minimum staffing levels were accurate throughout the document, to further clarify the admission criteria, and to remove outdated information included in error.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector reviewed the record of incidents maintained in the centre. All adverse incidents, as outlined in this regulation, had been notified to the Chief Inspector.

Judgment: Compliant

Regulation 34: Complaints procedure

An accessible complaints procedure was available in the centre. A review of the complaints log demonstrated that any complaints made were investigated promptly. However, a complaint had been closed and the satisfaction of the complainant recorded before the matter was resolved.

Judgment: Substantially compliant

Quality and safety

Residents reported that they were happy living in this centre. A review of documentation and the inspector's conversations and observations indicated that residents' rights were promoted and that they were encouraged and supported to be involved in activities that they enjoyed. As evidenced by the almost full implementation of the compliance plan submitted following the last inspection, a significant amount of work had been completed in the previous eight months. In addition to these actions, a new format had been introduced to document residents' individualised assessments and personal plans. The provider aimed to have each resident's plan in this revised format by the end of the year. Management also spoke with the inspector about plans regarding the provision of respite in the centre. Findings from this inspection identified that additional improvements were required in these areas. As outlined previously, medication management practices in the centre also required significant improvement.

Some of the residents who lived in this centre had busy, active lives. Two had jobs and others attended day services and other group activities on certain days during the week. When walking through the centre, there were indications of the various activities that residents participated in when in the centre. There was a poster about a World Cup sweepstakes and a karaoke machine in the dining room. The inspector was informed that some residents were particularly interested in this tournament and watched matches together on the large television. Photographs on display throughout the centre and in residents' personal plans showed visits to a local market, a musical, pubs, concerts in the nearby Marquee, a museum, and residents attending a League of Ireland football match. Residents also gathered to celebrate birthdays and many had participated in a mini-marathon together. Since the March 2022 inspection there were more wheelchair-accessible vehicles available to residents and volunteer drivers had been recruited.

The inspector reviewed a sample of the residents' assessments and personal plans. These provided guidance on the support to be provided to residents. Information was available regarding residents' interests, likes and dislikes, the important people in their lives, and daily support needs including communication abilities and preferences, personal care, healthcare and other person-specific needs such as mealtime support plans. It was identified that a multidisciplinary review of each personal plan had not been completed in the previous 12 months, as is required by the regulations. In addition not all elements of residents' personal plans had been reviewed at least annually. Examples of support plans that had exceeded this review timeframe included personal emergency evacuation plans, guidelines regarding dysphagia, and summary documents to be brought should a resident require a hospital admission. This shortcoming was also identified when the inspector reviewed a sample of the personal plans for those who accessed respite in the centre.

11 people had accessed the respite service since May 2022. As outlined in the opening section of this report, it was hoped to increase the number of people who

accessed this service and the number of nights it was provided. In general respite stays lasted four days. The assessments and personal plans of those who had accessed the respite service required significant improvement. Of the sample reviewed, not all assessments had been completed in full. For example, there was no information documented to support an assessment of one resident's medical needs. One resident, who stayed in the centre on four occasions in 2022, had a blank respite support plan. Missing person plans were also incomplete. The inspector noted that there were no notes available regarding one resident's most recent stay. When asked if this had gone ahead, management advised that it had and told the inspector that this resident had required nursing input regarding a chronic health matter during this time. Records of the nursing care provided were not available. This is a requirement of the regulations. Management advised that they would be undertaking a review of personal plans, templates and recording processes as part of their current focus on resuming the respite service at full capacity.

Residents' physical healthcare needs were well met in the centre. Residents had an annual healthcare assessment. Where a healthcare need had been identified a corresponding healthcare plan was in place. There was evidence of input from, and regular appointments with, medical practitioners including specialist consultants as required. There was also evidence of input from health and social care professionals such as physiotherapists and occupational therapists. A number of residents had documented recommendations regarding feeding, eating, drinking and swallowing. As previously outlined, not all of these had been reviewed in the previous 12 months. Management advised that where any concerns or changes had been noted, reviews were arranged. Many residents living in the centre chose to manage their healthcare themselves, only occasionally requesting staff support in this area. Where staff had provided support there was evidence of regular review and improved health outcomes. A summary document had been developed for each full-time resident to be brought with them should they require a hospital admission.

In the records of adverse incidents and other documents, and when speaking with staff, there were repeated references to a number of residents experiencing poor mental health at times. However, on review of their personal plans it was noted there were no mental health support plans in place. Similarly, it was identified that some residents may at times engage in behaviours that pose a challenge for them or others. Despite this, there were no plans in place outlining proactive approaches to prevent or reduce the likelihood of an incident occurring, or response plans to be implemented in the event of an incident. Management advised, and it was documented in meeting minutes, that they were trying to source multidisciplinary input in this area but to date had not been successful.

A restrictive practices audit had been completed which resulted in additional measures being implemented to make the centre more accessible for residents. The acknowledged environmental restraint of the commercial kitchen being inaccessible to residents had been somewhat mitigated by the development of the residents' lounge. All restrictions used in the centre were subject to regular review. Management displayed a commitment to providing a restraint-free environment in

the centre.

Residents’ personal plans also included plans to maximise their personal development in accordance with their wishes, as is required by the regulations. Personal development goals outlined what each resident wanted to achieve in the year. They included skills residents wished to learn, such as driving, or activities they wished to resume, such as swimming. These goals were personal to the residents and reflected their interests. Regular reviews of these goals were not always documented. It was therefore not always possible to determine what, if any, progress had been made in achieving these goals. Management advised that they had also recognised this inconsistency and that the staff team were now reviewing residents’ goals with them monthly.

The inspector reviewed a sample of risk assessments. These were subject to routine review. Risk assessments were comprehensive and related to a broad range of identified hazards. On review, it was identified that some of the assigned impact ratings were not reflective of the risk posed by the identified hazards. It was also identified that risk assessments were not always updated following related adverse incidents. For example, one resident had a diagnosed and documented allergy to a certain medicine. A risk assessment was in place regarding this, however neither the narrative or risk ratings reflected that this resident had been prescribed and had taken this medicine in error two months prior to this inspection. Risk management therefore needed to be more dynamic and reflective of the current circumstances in the centre.

A number of residents in the centre had safeguarding plans. Although these plans were regularly reviewed, it was difficult to determine from these records what actions were in progress and which had been completed to keep residents safe. From speaking with management, the inspector was assured that the required safeguards were present. Management advised that they would review the associated documentation to ensure it was clearer. At the time of the last inspection there were two incidents of alleged abuse of residents pending investigation in the centre. In the course of that inspection another alleged incident requiring investigation was reported. Since then, one of these investigations had concluded and the remaining two were underway. The provider had liaised with the local community safeguarding teams regarding these matters and this cooperation and consultation was ongoing.

The inspector reviewed some of the medication management processes in place. It was identified that increased oversight and improved implementation of the provider's policy was required. When walking around the centre, the inspector spent some time in the area where medication was stored. Medicines were stored in a secure area in a designated area of an office. Although temperature records for this area were being noted daily, no action had been taken to address the issue that the temperature was too high, according to the provider’s own guidance, to ensure that medicines were stored correctly. This situation had been ongoing for over six weeks. Management put effective measures in place on the day of the inspection.

When looking at the medicines stored in this area it was noted that the dates bottles

were opened were recorded on some but not others. The label on one medicine had been written on in pen, changing the dose outlined on the printed label. It was not clear who and had made this change or when. These poor practices were not in keeping with the provider's policy and procedures. The provider's policy also stated that each resident's prescription record was to be updated every six months. This was not consistently implemented in the centre. On review of one prescription it was noted that although one medicine had been discontinued, this was not clearly indicated. The dosage of another medicine was also unclear with two staff reporting different interpretations to the inspector. Staff obtained a revised printed label and an updated, clearer prescription by the close of inspection.

The inspector then reviewed the medication administration records where further areas for improvement were identified. One administration sheet was not consistent with the prescription and included the same PRN medicine (medicine only taken as the need arises) twice. As a result there was a risk that the maximum dose could be exceeded. It was also noted that although a resident was prescribed a medicine to be administered routinely and an additional dose to be administered on a PRN (only as the need arises) basis, it was only included on the administration record once. It was therefore difficult to determine the dose that had been administered. This was also not consistent with the system in place in the centre where the administration records for routine and PRN medicines were recorded separately.

A medication audit had been undertaken which had not identified all of these issues. Where some had been identified, for example that prescriptions were not updated every six months, actions had not been taken to address the matter. At the close of inspection, due to these findings, management advised their intention to revise the audit in place and assign the responsibility to complete these audits to a member of the management team.

As outlined in the opening section a number of improvements had been made to the premises in recent months. These included additional facilities such as the resident's lounge, a large television in the dining room, and the projector and screen in the upstairs communal area. Works had been done to enhance the outdoor areas and the accessibility of some residents' bedrooms had been improved through the installation of automatic doors. When walking around the designated centre, it was observed to be clean and bright. The centre was decorated for Christmas and there were a number of recently taken photographs on display. These added a more homely atmosphere to the large centre. Some areas requiring maintenance were identified, including the skirting area in one of the communal toilets and the wall in the laundry room. Painting was also required in some bedrooms. Some areas also required more extensive cleaning. These included the seals and grouting in the bathrooms used by those assessing respite.

Laundry equipment was available in a designated room. Systems were in place to ensure that clean and unclean items were kept separate. Posters on display indicated that a colour-coded cleaning system was in use in the centre whereby certain coloured equipment was used in specific areas to reduce the risk of cross contamination. However, it was evident on the day of inspection, that this colour coded system was not being used as outlined. The centre also had a sluice room.

The general and clinical waste bins stored in this room were observed to be rusted. Given these damaged surfaces it would not be possible to clean them effectively.

There was evidence of good infection prevention and control (IPC) practices and systems in the centre. An IPC lead had been identified. All staff had completed IPC training, including hand hygiene. Staff member's practical implementation of hand hygiene skills were also assessed. Supplies of personal protective equipment (PPE) were available, as were first aid kits. Of the sample reviewed by the inspector, all items were in date. There had been one confirmed case of COVID-19 in a resident of the centre since the last inspection and they had been supported to recover in their home.

During the last inspection, an inspector read a fire risk assessment that identified a number of actions to be completed. At that time, these had not been progressed. This and other findings resulted in a not compliant judgment with the regulation regarding fire precautions. There was evidence on this inspection that not only had those matters been addressed but that additional guidance and input had been provided by a competent person in the area of fire safety. Work completed included staff training, fire stopping in the boiler area, corrections to fire doors, portable appliance testing, and a revision of residents' personal emergency evacuation plans (PEEPs). A repeat fire panel had also been installed near the staff sleepover area. This ensured, that if woken during the night by a fire alarm, staff could determine the location of the fire without having to pass several high risk areas. There was a schedule in place to complete fire drills and input had been received in the evacuation procedure to be followed. On review of the drill records maintained in the centre, it was difficult to determine if they were completed within timeframes assessed as safe by the provider. Management advised that a phased evacuation procedure was now in place. It was acknowledged that the records maintained needed to better reflect this procedure and to ensure that the time taken to move all residents from the compartment where the fire was located was recorded. It was also noted that some PEEPs had not been reviewed in the previous 12 months, as required, or to reflect recent changes. A follow-up fire risk assessment was scheduled for January 2023.

Regulation 11: Visits

Residents were free to receive visitors if they wished and both communal and private spaces were available to facilitate this.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had access and opportunities to engage in activities in line with their preferences, interests and wishes. Opportunities were provided to participate in a wide range of activities in the centre and the local community.

Judgment: Compliant

Regulation 17: Premises

The centre was clean, suitably decorated, well-maintained and accessible to the residents living there. A number of improvement works had been completed in recent months. The premises were laid out to meet the aims and objectives of the service and the needs of residents. Each resident had their own bedroom and access to communal spaces and cooking facilities. Some areas required maintenance and enhanced cleaning to ensure the centre was kept in a good state of repair.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

Menus on display indicated that choices were offered at meal times. Staff had a good knowledge of residents' individual dietary needs. The kitchen in the residents' lounge and storage facilities in individual bedrooms facilitated residents to store food in hygienic conditions.

Judgment: Compliant

Regulation 26: Risk management procedures

Risk assessments required review to ensure that they took into account recent, related adverse incidents that occurred in the centre and that the risk ratings were an accurate reflection of the risk posed by the identified hazards.

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 staff team had completed training in

infection prevention and control, including hand hygiene. The centre was observed to be clean. However there were some damaged surfaces evident which therefore could not be cleaned effectively. It was also noted that the colour-coded cleaning system designed to reduce the risk of cross contamination between different areas in the centre was not being implemented.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Significant improvements had been made in the area of fire safety in the centre. Fire safety systems in place in this designated centre included fire alarms, emergency lighting and fire fighting equipment. Fire drills were taking place regularly. It was identified that the documentation regarding these drills required improvement to demonstrate if the phased evacuation plan was taking place within a time assessed as safe by the provider.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Many of the practices relating to the ordering, prescribing, storage, and administration of medicines as outlined in the provider's own policy were not being implemented in the centre. Areas requiring improvement included medication storage conditions, prescription and administration records, and the labelling of medicines. These areas of poor practice increased the risk of medication errors in the centre. Many of the identified issues were addressed by the close of this inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

When reviewing the documentation relating to those who accessed respite in the centre, it was identified that some assessments were incomplete, and that one resident did not have a personal plan in place. For the long-term and respite residents who did have a personal plan, not all had been subject to a multidisciplinary review in the previous 12 months, as is required by the regulations. In addition, not all elements of residents' personal plans had been reviewed within that timeframe. Despite repeated references to some residents having mental health

needs, there were no related support plans in place. Although a new review system had been recently been introduced to ensure consistent reviews of residents' personal development goals, there was no evidence to date that it had been implemented.

Judgment: Not compliant

Regulation 6: Health care

Residents' healthcare needs were well met in the centre. Residents had access to healthcare professionals and health and social care professionals in line with their assessed needs.

Judgment: Compliant

Regulation 7: Positive behavioural support

Not all residents who required one, had a recently reviewed behaviour support plan in place. As a result staff did not have up-to-date knowledge to respond, and to support residents to manage their behaviour. At the time of this inspection, these incidents had occurred at a low frequency and did not pose a significant risk. There was evidence that the provider was actively attempting to source multidisciplinary input in this area. Any restrictive procedures in place in the centre were closely monitored and regularly reviewed. Management demonstrated a commitment to promoting a restraint-free environment. The training referenced in this regulation is addressed under Regulation 16.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had systems in place to protect residents from all forms of abuse. Safeguarding plans were regularly reviewed. All staff had completed training in relation to safeguarding residents and the prevention, detection and response to abuse.

Judgment: Compliant

Regulation 9: Residents' rights

The centre was operated in a manner that respected residents’ rights. The terms for living in the centre had been revised to be more consistent with a human rights based approach to social care. Staff were in the process of completing human rights training. Residents’ meetings were held monthly in the centre. In these meetings residents' contributions were encouraged and acted upon. Residents were encouraged and supported to exercise independence, choice and control while living in the centre. Some residents chose to lead and facilitate their own planning and review meetings and this was also encouraged.

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 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Not 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	Compliant

Regulation 9: Residents' rights	Compliant

Compliance Plan for Abode Doorway to Life CLG OSV-0002411

Inspection ID: MON-0038067

Date of inspection: 29/11/2022

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Behaviour support training has been sourced and will commence on 21st of February 2023 and be completed by 22nd February 2023.</td></tr>
<tr><td>Regulation 21: Records</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 21: Records:
Nursing record for one identified resident (Respite user) has been completed on 9th of January 2023.</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
Improvements required in:

• Individualized assessment and personal planning for residents</td></tr>
</table>

Social Care worker monthly care plan audit in place and has commenced 1st of January 2023.
Person in Charge Quarterly resident Care Plan audit developed and commenced 3rd of January 2023.
• Assessment and development of personal plans for those accessing respite
Social Care workers have been designated specific respite care plans to update and maintain from 1st of January 2023.
Person in Charge Quarterly Respite Care Plan audit developed and commenced 3rd of January 2023.

• Oversight and implementation of the providers policies and procedures regarding medication management
CMN1 to commence quarterly medication audit to ensure adequate oversight of medication policies and procedures by 31st of January 2023.
CMN1 will meet weekly with staff nurse to support best practice procedures – Commenced 9th of January 2023

• Oversight in staff training
PIC has reviewed and updated all staff training records and now maintains these. Completed 22nd December 2022

• Implementation of Infection prevention control measures
CNM1 commenced role of Infection Prevention control Lead following training on 22nd of November 2022.
Infection Control audit to be developed by 28th of February 2023.
Infection prevention control lead to review cleaning schedules in line with Infection prevention and control guidelines by 28th of February 2023

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
• Resident’s contracts of care have been reviewed, updated and signed by all residents. Completed on 29th of December 2022.
• Respite contract template has been reviewed/ updated and completion of this is now part of the required admission documentation for respite users going forward. This is captured on respite application processing form completed on 5th of January 2023.

Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The statement of purpose has been reviewed to update staffing whole-time equivalents (WTE) and ensure minimum staffing levels are accurate throughout the document. The admission criteria is clarified and outdated information included in error removed. Completed 14th of December 2022.	

Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: PIC reviewed the complaint and re-opened on 1st of December 2022. The complaint will remain open until fully rectified.	

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: PIC and Housing development officer (involved in organization of maintenance) did a walk around and compiled a list of required maintenance to building. Identified maintenance has been placed in the internal maintenance log with an expected completion date of 30th of March 2023. Identified areas that required enhanced cleaning were completed by internal maintenance on 13th of December 2022.	

Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Social Care workers are completing a full review on all individual risk assessments as part	

of their monthly care plan audit which commenced 1st of January 2023 to be completed by 31st of January 2023.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
• Damaged Surfaces
Work commenced on identified damaged surfaces on 12th of December 2022 to be completed by 31st of March 2023.

• Colour coded cleaning system
Colour coded cleaning system has been reviewed. New mops and colour coded mop heads have been purchased and new signage explaining the colour coding system was introduced on 14th of December 2022.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Documentation on fire drills
Documentation on fire drills has been reviewed to clarify the safe assessed time for phased evacuation on 6th of December 2022.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
• Medication storage conditions
Environment in which the medication is stored was changed to ensure the appropriate storage temperature of medication on 29th of November 2022

The medication fridge was moved to a locked room as per medication policy on 29th of

November 2022

• Prescription and administration records
A full review of all prescription and administration records commenced on 30th of November 2022, to be completed by 31st of January 2023.

• Labeling of medication
New medication label obtained on 29th of November 2022. Staff reminded via HIQA Feedback meetings on the 6th, 8th and 16th of December 2022 of policy on labeling and transcribing of medication.

CMN1 to commence quarterly medication audit to ensure adequate oversight of medication policies and procedures by 31st of January 2023.

CMN1 will meet weekly with staff nurse to support best practice procedures – Commenced 9th of January 2023

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:
• Complete personal Plans
Complete personal plans now in place for all current respite users and residents completed by 1st of January 2023

• Multi-Disciplinary reviews
Remaining multidisciplinary reviews will have taken place by 28th of February 2023.

• Review system for care plans
Social Care worker monthly care plan audit in place and has commenced 1st of January 2023.

Social Care workers have been designated specific respite care plans to update and maintain from 1st of January 2023.

Person in Charge Quarterly Respite Care Plan audit developed and commenced 3rd of January 2023.

Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • Residents who require a positive behavior support plan Enquiry sent for psychologist to complete mental health support plans/ proactive/ reactive strategies for residents on 3rd of January 2023. Psychologist to complete mental health support plans/ proactive/ reactive strategies for residents who require same by 30th of June 2023	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	22/02/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/03/2023
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for	Substantially Compliant	Yellow	09/01/2023

	inspection by the chief inspector.			
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.	Substantially Compliant	Yellow	28/02/2023
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Substantially Compliant	Yellow	05/01/2023
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	31/01/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare	Substantially Compliant	Yellow	31/03/2023

	associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	06/12/2022
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that any medicine that is kept in the designated centre is stored securely.	Not Compliant	Orange	31/01/2023
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	14/12/2022
Regulation 34(2)(f)	The registered provider shall ensure that the	Substantially Compliant	Yellow	01/12/2022

	nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.	Substantially Compliant	Yellow	01/01/2023
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	31/01/2023
Regulation 05(4)(a)	The person in charge shall, no later than 28 days	Not Compliant	Orange	01/01/2023

	after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).			
Regulation 05(6)(a)	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 be multidisciplinary.	Substantially Compliant	Yellow	28/02/2023
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.	Substantially Compliant	Yellow	31/01/2023
Regulation 05(6)(d)	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	Substantially Compliant	Yellow	31/01/2023

	needs or circumstances, which review shall take into account changes in circumstances and new developments.			
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/06/2023